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ABSTRACT

Presented are 10 papers given at a conference on the design and implementation of comprehensive educational programs and the delivery of related services to emotionally handicapped children. Entries include the following titles and authors: "Seriously Emotionally Disturbed Children" (J. Spence); "The Rutland Center--Developmental Therapy Model: A Practical Model for Emotionally Disturbed Children" (A. Beardsley); "Involving Parents of Severely Emotionally Disturbed Children in the Treatment Process" (R. Simpson); "Administrative, Logistical and Fiscal Considerations in the Implementation of CORBEH's (Center at Oregon for Research in the Behavioral Education of the Handicapped) Behavior Management Packages for the Remediation of Specific Classroom Behavior Disorders" (H. Walker); "The Administration of an Agency that Recognizes It Cannot Be All Things to All Children and Their Families: An Ecological Approach" (D. Hartstern); "Controlling Academic and Social Performance Using an Instructional Delivery Approach" (E. Gickling); "The Bailey Program for Severely Disturbed Adolescents" (B. McDonald and A. Evans); "Division TEACCH (Treatment and Education of Autistic, psychotic and related Communications handicapped CHildren): Toward a Statewide Network of Public School Services for the Austistic Child and His Family" (L. Marcus, et al.); "Cooperative Programing for Behavior Disordered Students: A Model Program" (C. McCormick); and "Child Abuse And Neglect: An Educational Concern" (M. McCaffrey). Among appendixes are descriptions of 24 programs serving the emotionally handicapped and a list of materials displayed at the conference. (SBH)

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Programming for the Emotionally Handicapped: *Administrative Considerations*

A Document for Planning

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Conference Proceedings
May 17-19, 1977

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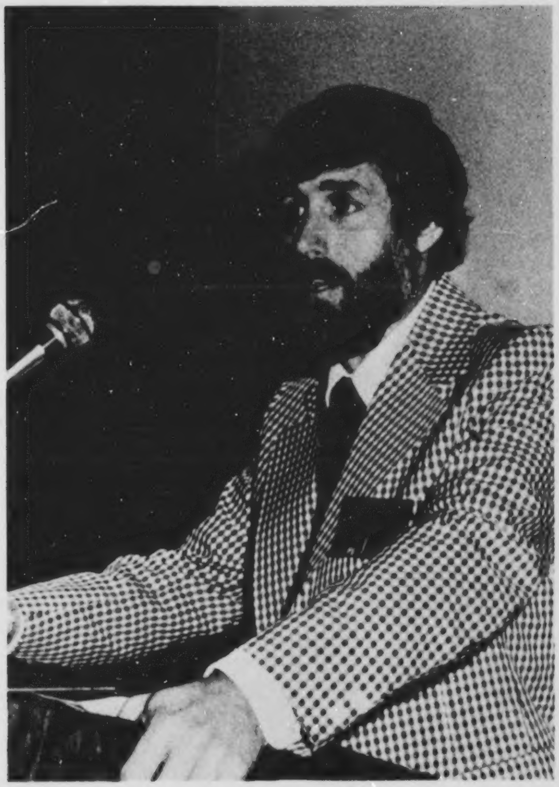
Mid-East Regional Resource Center
MERRC
George Washington University
Washington, D.C. 20006

Coordinating Office for
Regional Resource Centers
CORRC
University of Kentucky
Lexington, Kentucky, 40506

EC 103080

Linda S. Foley
Conference Coordinator



Joseph C. Todd
Conference Coordinator

Acknowledgements

Several individuals who ably assisted with conference planning and presentation on May 17-19, 1977 in Washington, D.C. as well as those who contributed significantly to the production of this document deserve mention here.

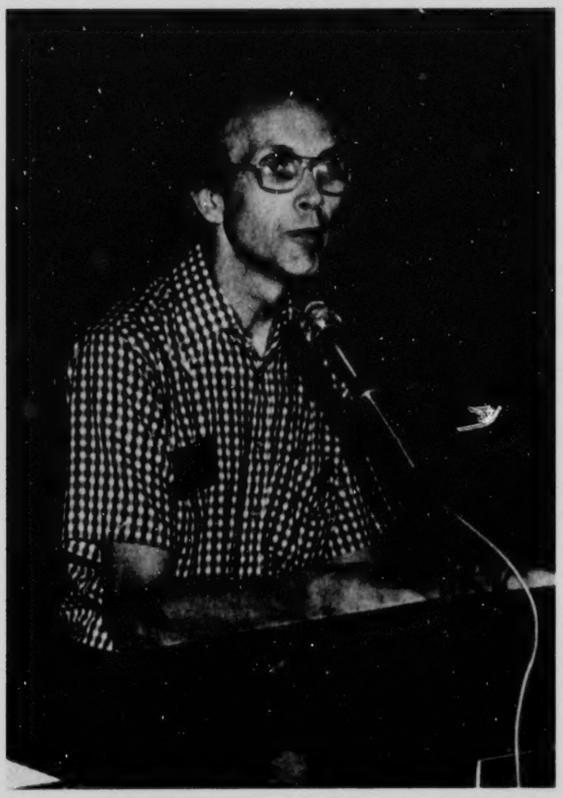
We extend sincere thanks to Pat Buchignani and Margaret Sweitzer for their assistance with the compilation and editing of the Compendium of Programs found in Appendix A, to Amy Green for her orchestration of the physical arrangements and assistance given to the conference participants and to Manfred Brand for providing the audio-visual capacity needed during conference delivery and the photography found throughout this document. In particular, we thank Carol Holland for assembling the extensive number of teaching materials displayed at the conference and preparing the companion list found in Appendix B, as well as for her continued input throughout document design and production.

Along with those mentioned above, we thank the conference presenters and participants for their support, enthusiasm, and candid critique. We anticipate that our collective efforts will yield positive outcomes for the population of children addressed herein.

Linda S. Foley, MERRC
Conference Coordinator

Joseph C. Todd, CORRC
Conference Coordinator

August, 1977



Dr. Raymond S. Cottrell
Director, MERRC

Table of Contents

Page

Introduction vii

Presentations

"Seriously Emotionally Disturbed Children" 1
JOYCE SPENCE, Ph.D.

"The Rutland Center — Developmental Therapy Model:.A Practical Model for Emotionally Disturbed Children" 7
ANTHONY BEARDSLEY

"Involving Parents of Severely Emotionally Disturbed Children in the Treatment Process" 12
RICHARD SIMPSON, Ed.D.

"Administrative, Logistical and Fiscal Considerations in the Implementation of CORBEH's Behavior Management Packages for the Remediation of Specific Classroom Behavior Disorders" 18
HILL M. WALKER, Ph.D.

"The Administration of an Agency that Recognizes It Cannot Be All Things to All Children and their Families: An Ecological Approach" 30
DON HARTSTERN

"Division TEACCH: Toward a Statewide Network of Public School Services for the Autistic Child and His Family" 34
LEE M. MARCUS, Ph.D., LOUIS P. SEMRAU, Ph.D., and
ERIC SCHOPLER, Ph.D.

"Controlling Academic and Social Performance Using an Instructional Delivery Approach" 45
ED GICKLING, Ph.D.

"The Bailey Program for Severely Disturbed Adolescents" 49
BYRON McDONALD/ANN EVANS

"Cooperative Programming for Behavior Disordered Students: A Model Program" 58
CHARLES McCORMICK, Ed.D./Mark L. Becker, ACSW

"Child Abuse and Neglect: An Educational Concern" 69
MARY McCAFFREY, Ed.D.

Appendix A: Programs Serving the Emotionally Handicapped 79

Appendix B: Materials List 101

Appendix C: Conference Agenda and Evaluation 109

Appendix D: Conference Participants 117

I. Production Staff
II. Presenters
III. Attendees

7

Introduction

This document has been prepared and disseminated in order that those at both the state and local education agency level responsible for the delivery of services to emotionally handicapped children may be aided in their design and implementation of comprehensive educational programs along with the delivery of related services to this population. The material contained herein was presented at a regional conference co-sponsored by the Mid-East Regional Resource Center (MERRC) and the Coordinating Office for Regional Resource Centers (CORRC) May 17-19, 1977 in Washington, D.C.

Catalytic to the design and delivery of the conference along with the subsequent production of this follow-up document was a recommendation from Theodore R. Drain, Director, Division for Exceptional Children, North Carolina, that resources available through MERRC be used to assist states in region twelve as they address the needs of their emotionally handicapped population. His proposal was seconded by James T. Micklem, Director, Division of Special Education, Virginia, who added, "Probably no single group of children presents a greater challenge to the educator than does this group of youngsters." This statement appears warranted in that the figures quoted by the National Advisory Committee on the Handicapped in American Education, June, 1976 revealed that of the number of children identified nationally as emotionally disturbed (Ages 0-19 years) during school year 1975-1976, only 19% were being served. This information, together with the enactment of Public Law 94-142, which guarantees a free appropriate public education to all handicapped children in the least restrictive environment, stimulated the Advisory Board, consisting of the eight State Directors for Special Education in region twelve to unanimously support the request for a MERRC supported conference.

As the implications of such a conference extend beyond the boundaries of region twelve, MERRC sought and received assistance from CORRC. Together, they planned a conference that would showcase exemplary programs for emotionally handicapped children and deal with many of the unresolved issues pertaining to definition, identification, the utilization of community resources, and inter-agency cooperation. To this end, each RRC was invited to send two representatives who have primary responsibility for assisting clients in each of their respective regions with programming for emotionally handicapped children. Additionally, each state in region twelve was invited to send five participants, drawing from the following: State Director of Special Education, State Director of Pupil Personnel Services, State Consultant for School Psychology, State Consultant for Emotionally Handicapped Programs and one representative from the Department of Human Resources (or the equivalent to these roles in each state.)

A search was conducted to identify noteworthy programs across the country. As with any conference this size, only a sample of those programs identified could be presented. Each speaker was asked to address as appropriate, when presenting their respective programs, the following items:

1. administrative staff requirements,
2. staff/organizational structure (include line/staff chart, if appropriate),
3. fiscal resources,
4. degree of inter-agency involvement,
5. flow chart depicting sequential steps in program,
6. project operating cost requirements,
7. student population (age range, severity, etc.) enrolled in your program,
8. criteria for student admission,
9. criteria used for teacher selection,
10. basic intervention model, and
11. relationship between regular educators and project staff.

The expected conference outcomes were:

1. to give brief overview and clarify those elements of P.L. 94-142 that relate to *full service delivery* as

well as those relating specifically to emotionally handicapped students;

2. to aid participants in identifying the emotionally handicapped population in their state;
3. to expose participants to *exemplary service models* being implemented by various states at the local district/school level;
4. to assist participants in *implementing* required service models, through discussion of administration level considerations, i.e., program overview, staffing/organizational structures, programmatic as well as fiscal resources required, etc.;
5. to aid participants in developing *interagency cooperation* for successful service delivery to this population within their home state;
6. to acquaint participants with strategies for developing the in-service training models/programs that are needed, in addition to those already existing pre-service training efforts; and
7. to provide a forum for the states in region twelve and RRC representatives to share information with one another about successful programming efforts within their home states for greater overall progress to the entire region.

At the outset, this document was deemed an integral part of the overall effort. It contains a record of the conference, the nine presentations increased by one additional paper, a compendium of programs for the emotionally handicapped, a materials list, the conference agenda accompanied by an evaluation of the conference proceedings, and a listing of the conference participants. It is intended that this document will be a valuable resource to those responsible for administering and/or assisting with the administration and implementation of programs and services to emotionally handicapped children (or are RRC program staff assigned to assist client states) by providing pertinent information for these tasks.

Linda S. Foley

Seriously Emotionally Disturbed Children: Council for Children with Behavioral Disorders, Implications of Pl 94-142, Private Alternatives to Public Education

Joyce Spence, Ph.D.

As one of the consultants selected to speak to you today, I was asked to address three areas with respect to the topic of behavioral disorders in children.

First, I will discuss with you the Council for Children with Behavioral Disorders from my vantage point, as President-Elect. Secondly, I will project, as I see it, the impact of P.L. 94-142, Education of All Handicapped Children Act of 1975, specifically in relation to the emotionally handicapped and the administration of programs designed for the severely emotionally disturbed. Finally, I will describe the Child Center, of which I am director, a treatment agency for seriously emotionally disturbed children.

Council for Children with Behavioral Disorders

The Council for Children with Behavioral Disorders began in 1962 with the purpose being to promote the education and general welfare of children with behavioral disorders and to encourage professional growth and research to better understand the problems of those same children. Although we are one of the more recently formed Divisions, we rank third in membership among the twelve divisions with over 5,000 members. A particularly interesting aspect of our membership is the wide diversity of professional groups represented; special education teachers of behaviorally disordered children, teachers in facilities for the delinquent, psychologists, social workers, college and university professors, therapists, and undergraduates and graduate students all are represented.

About three years ago we conducted a very interesting study in which we surveyed the entire membership, using a Delphi-type instrument, to try to determine future goals and services of the organization. The information we gained from that study has guided us in several directions since then. Those directions largely will be what I would like to share with you. A number of important bits of information became known to us from membership; the most significant being that those members were all very individual; they saw the problems to be very different, they had very idiosyncratic needs in different regions, and proposed quite diverse solutions to the problems as they perceive them in the area of behavioral disorders. Another message which emerged loud and clear was that problems with behaviorally disordered children are very real, are faced daily by many people, and leave little room for academic disagreements about diagnosis or definition. A third primary message was that the organization must *do* something for its members and something for children it purports to serve. Members of CCBD are acutely sensitive to the reality that there is little or no national conscience for "our" children. We have no active parent originated group like National Association for Retarded Citizens or Society for Autistic Children, no Presidential inspired focus such as March of Dimes, or celebrity sponsored effort as Muscular Dystrophy. We have not been able to define our population, not even to come close to a commonly accepted definition. Every day in our work we must defend our clients against lack of understanding and sometimes even downright hostility from those who see that our children have problems, alright, but nothing that good discipline and maybe a spanking would not cure. Even among those people who themselves know they work with behaviorally disordered children are some who may not always be sure just what other types of children are called behaviorally disordered, and may suffer from significant misunderstanding about those other children shuttled in a different direction through the system, and may actually be as afraid of those "other" kinds of children as the public at large.

It is against this backdrop of great personal, regional, and professional diversity; against an orientation toward real as opposed to academic problem solving; and against the intense need for an organized conceptual and actual leadership that CCBD in the past few years has attempted to direct itself.

I have alluded to some general issues which remain at the core of the future directions of CCBD. I would like to elaborate somewhat on those. Following that, I will share with you some services to members we are now providing.

ISSUES

We are reminded almost daily that our world is changing very fast and that none of us can see too clearly the full impact of those changes. It is difficult to find clean, articulate research to help us parcel out long-term effects of changing social and cultural values. All of us have likely felt the changing expectations of family and martial roles. We know there are far more single-parent families than ever before; in some schools 1 out of every 2 children lives in a single parent home. Our rules for sex roles are not clear; moral standards are in a flux; greater freedom is perceived as positive in many spheres of functioning and yet we continue to feel considerable anxiety when we cannot discern the boundaries, and our once accepted community leaders, teachers, or religious figures share our doubts and join us in groping for limits. It is clear that in a disynchronized society we are going to over-adjust, redefine rules more rigidly and as a consequence identify more behaviorally disordered children.

An organization like CCBD must squarely address the social identification issue of behavioral disorders and recognize that our disability group is largely defined only relative to the defining group, and has little or no inherent characteristics to allow a clean researchable definition. This must disallow, of course, the small percentage of our children who suffer from diagnosable or apparently organic clinical syndromes.

Because our child and family client population is identified so often by its effect on the world around it, rather than because of its inherent qualities, we find a number of organized professional groups waiting in line to solve our client's problems. Although CCBD is a division of an organization which is heavily educational in orientation, we must think beyond special education for our clients. The children we serve, probably more than any of the others designated exceptional, hook into mental health, social welfare, protective services, public health, and medicine. The service setting simply cannot work in isolation.

CCBD must work to develop more effective mechanisms to relate to the other professional organizations who have as their target the child labeled emotionally disturbed, abused and/or neglected, autistic, and child and family disordered. We can do this through formal liaison with other groups, through jointly sponsored meetings and symposia and through the continued efforts at the service delivery level to maintain a primary focus on a range of services to meet child and family needs, rather than on turf protection.

I am proud of what we are trying to do in CCBD now, even though we have a long way to go. Partly as a result of the study we completed which I mentioned, we have an excellent journal available to members. Albert Fink from Indiana University is the editor and has managed to put together four issues of quite an excellent caliber with plans to further refine and define continued directions. We will continue the journal and see it as just one of several types of publications available to help address the issues and service needs in behavioral disorders. An example of both of those is the upcoming issue published jointly with learning disabilities to focus on the common dual problem of behavioral and learning disorders.

Another major thrust we are taking is toward regional services. As I mentioned earlier, we discovered enormous variability in needs and concerns throughout the country. As an organization we have decided to focus on those regional needs by developing a regional network of people and are working to provide a real and effective communications system. Ultimately we hope that those regions can tell us what they want and need, and we can move entirely away from the notion of national conventions, national services and so on. This seems very congruent with what Wolf Wolfensburger has described as the future for systems of human services, with great emphasis on client initiated, decentralized service.

In summary, the direction of CCBD, as I see it, is going in three primary thrusts: 1) the continued articulation of complex and multiple-origin issues as they relate to behaviorally disordered children and their families, the institutions which define and serve them, and the purpose and goals toward which we must continually direct ourselves for the best good of all; 2) continued communications services at several levels to meet different service delivery needs such as high quality, professional journals, specific topical publications, invited monographs, materials and methods descriptions, media packages and legislative reviews; and 3) the continued development of local and regional awareness and activism along with the emphasis on regional services, to result in continuing activities appropriate to, focused on, and designed by those participating in that region.

Project Impact of PL 94-142 on the Emotionally Handicapped

I was asked to comment briefly on my understanding of the impact of PL 94-143 the so-called civil rights law for the Handicapped, as it relates to the emotionally disturbed.

Two fears are expressed to me quite often. One, from my colleagues in mental health and child welfare services, basically goes as follows: Are you familiar with the new law for handicapped children? Do you know that it requires public schools to educate *all* children, even emotionally disturbed? The nature and tenor of the questions, along with subsequent discussion makes it clear that these people have great fears about their loss of impact into services for disturbed children, that they have little knowledge of, or faith in, the capacity of public education to deal with "our" children, and finally, that this new law, rather than helping children, can only deny proper mental health services by substituting narrow educational services. At its worst, the fantasy imagines the demise of mental health services for children as the educational monolith subsumes all under its federally powerful umbrella.

The other fear, expressed to me, comes from my colleagues in public education. The underlying question and fear, I think, is different. In the case of public school personnel, it seems there is much anxiety about the ability to program for a range of children who typically would not remain in school, such as autistic children, self-abusive children, chronically unsocialized, aggressive, acting out, actively psychotic, and so on down a laundry list of very scary problems that school personnel generally are not trained to deal with or remediate.

In both cases I believe the fears are unnecessary and relate to a problem, I noted earlier, of the almost complete lack of communication at all levels among professionals who must impact on emotionally disturbed children. In my own county of Lan, Oregon, there are estimated .5% severely emotionally disturbed, or 411 out of the 18 and under population of 82,212. Another 1,644, or 2% require psychiatric or other professional help and 6,166 or 7.5% could benefit from some form of intervention. R. Paul Thompson in a recent issue of "Exceptional Children", used the BEH estimate of 900,000 seriously emotionally disturbed children, nationally almost twice as many as the severely multiply handicapped. Depending on the level of severity one chooses, the estimates may range from .06% as psychotic, 2-3% as severely disturbed, or 3-10% as needing some form of help out of the total child population. With those kinds of numbers in mind, combined with the multiple problems of the families which go along with the child so often, there are problems aplenty for all of us, if we should decide to peek out from behind our collective professional fears and ask about the child, rather than our respective turfs.

Now, I would like to refer to the issue of social institutions that I alluded to earlier. Public schools, generally, have a primary responsibility in marking the tolerance limits in a given community. Typically, whatever value and belief systems are operating within a given culture or neighborhood they will be clearly reflected in that local school, and to an extent, the school is given some authority to define those limits, through text book selection, emphasis on discipline and so on. The point for us today vis a vis school administrators and emotionally disturbed children, is really how far can or should schools go in tolerating deviance from those norms. At what point does the tolerance and individualized programming infringe on the rights of the larger body of students. How far does one put up with bad language, provocativeness, raging anger and defiance, or subtle but distructive manipulation. What resources should the school marshall for the withdrawn, peculiar, isolated, and scapegoated child, especially when the family may be unavailable or uncooperative. How defensible are programs for the one half of the one percent which may cost five times as much as for another child and result in marginal changes and considerable anguish.

I wish I had an answer. I am not an unqualified supporter of the concept of mainstreaming all children, nor of the notion that public schools should serve all children. The new law, like many operating for years in several states, calls for an appropriate education for all children regardless of handicap. That is right and good. It is not appropriate that public schools should try and be all things to all people, nor attempt to provide all services to severely emotionally disturbed children. Severely emotionally disturbed children often need more than an educational opportunity. They may need intensive family intervention, protective services, residential or foster home care, individual or group psychotherapy, or even a secure lock-up facility. This is where mental health and child oriented social services come in; not instead of or not at all, but rather to supplement, to add to, to complement, to make complete a full range of options for children on the far end of the behavioral range.

One other point I wish to make about this law which really is rather troubling and will be problematic, I think, is related to the language of the definition: seriously emotionally disturbed. You will find many persons in the field who will strenously object to the term "emotional disturbance" and turn quite red in the face at the lack of objectivity. Most professionals prefer the term "behavioral disorders" because it says more accurately what it is we believe we are dealing with, at least in a way that is more clearly observable and understanding. Within the definition itself is a range of quite ambiguous words including "long period of time", "marked degree", "inability to build or maintain satisfactory relationship", "inappropriate types of behavior under normal circumstances", and so on. Now your "long period of time" and mine may not be the same, or to a "marked degree", or "inappropriate", or "normal", then again they may. This problem is nothing new of course, and we do, practically speaking, usually have clear consensus when we ask public school personnel to pick out the most disturbed child in any given grade level. There is an unwritten notion of sorts which shows us the clear deviants. But the fact that this civil rights law depends on such an ambiguous or at best shaky definition for administrative purposes is rather unnerving. My concern is that if it is as difficult as it appears to be for us to identify, relatively easily discernable racial and ethnic minorities, and to subsequently provide them with equal opportunities, how then will we be able to identify and provide services to handicapped children without first reaching an understanding as to their needs and a clarification of our intentions. At the best, the definition can be interpreted rather broadly and include a large range of children who could benefit from special education, counseling, and family services. At its worst, the definition can be interpreted to include only the most severely impaired child.

The Child Center

Getting on to my third purpose in speaking here: The Child Center. I will fall back on a popular phrase these days to place my agency in your administrative perspective; the Cascade of Services—the least restrictive to the most restrictive. The Child Center is a treatment agency for seriously emotionally disturbed children which could be placed on that diagram just this side of an institution; an alternative out-of-public school placement. We are a private, really quasi-public, non-profit, social service agency. We are administered by a local board of directors, which has legal authority and responsibility for policy making and implementation. The funding is from multiple sources and operates on a combination of purchase of service contracts and subcontracts with local and state mental health divisions, local school districts, county and city governments, state education offices, and private funds and fees. We are small. We serve 25 children and their families during a year. We are community based; draw our board from all walks of life including our clients, and are open to public scrutiny. We are relatively short term, 16-18 months, and never take a child from an already existing placement without a contract to return. The Child Center operates on the premise that the target child is only representative of the identified problem and that a great disservice will be done that child by working with him/her alone and not the entire family. Therefore we require a family contract before going beyond the initial telephone inquiry and we are very explicit in stating our mutual responsibilities and requirements in that contract. Families, including the child, become our client. The child happens to be registered and generates the money to run the program.

The Child Center does not separate treatment and education, even though we are called a treatment center for seriously emotionally disturbed children. A child learns how to read while he/she is learning better coping skills, how to maintain attention, how to express disappointment (about making an error) appropriately. A child works in a group to improve his/her self-esteem, develop skills in expressing and describing feelings, is given feedback and encouragement for appropriate coping while doing a science lesson. There is nothing new in the concept of making education really readiness for living, except that in a treatment setting those activities become very deliberate, very planned and are translated into continuously monitored behavioral goals and objectives which are carefully integrated across all behavioral settings in which the child may find himself.

The integrated education treatment model is especially appropriate in the context of the new law for handicapped children; it also addresses questions and concerns relating to service delivery expressed by school administrators. In the development of our treatment program three primary issues are considered 1) the role of the alternative placement setting in relation to the remainder of the child's community with the emphasis on a continuum of services; 2) the critical importance of maintenance of new skills acquired at The Child Center and the generalization to new settings or regular class placements; 3) the unique skills of the clinical teacher or mental health specialist as the primary treatment agent. I will elaborate briefly on these pivotal issues.

First, the placement setting must be firmly set in and defined by the community in which it operates. "Community-based" is a phrase so over-used as to almost be a cliche, yet retains a core of importance we cannot ignore. Such facilities tend to be cheaper; our cost per day is about half of some larger institutions for similar types of children. Children are kept closer to the current of their home and neighborhood, with a primary result being better facilitated maintenance and generalization after treatment. Some characteristics of community-based programs emphased in The Child Center are: 1) There's a revolving door at the front and back; children must be able to take all or part of the program along with a dose of the community in sizes they can handle; 2) other community agencies are an integral part of the program, participate in evaluating its effectiveness and are programmed into all phases of treatment planning; 3) parents, foster families, and other family members are perceived and responded to as clients; and 4) treatment responsibility is a shared one, with the primary decision-making responsibility at the level of delivery closest to the client.

The treatment agent, and the formulation of that as something more than the sum of a teacher and a counselor is the key to making the integrated model work.

Those of you in the related mental health service fields are aware of the changing structure and hierarchy of treatment in mental health agencies. The decisions for treatment were some years ago made by the physician in charge and delegated to child care workers, social workers, and teachers to implement. The reasons for that seemed reasonable at the time, considering that mental illness was thought to be a disease. Nowadays, however, we're much more concerned with the functional analysis of problem behaviors and more importantly the ways in which environmental systems affect child and family behavior. We want as little fragmentation of planning as possible; between agencies, between target clients, between treatment activities. To that end, a job function must be designed to be at the core of planning and implementation of services to severely deviant and dysfunctional children, for our purposes here this person is called the child mental health specialist.

Treatment planning is a complex and highly important activity which requires experience, knowledge, and maturity. It also requires some sense about what the end goals are. Of course, for each child the goals are going to be very individual. However, there are some very broad goals which can be stated for all our disturbed children, and for that matter, our not-disturbed children alike. These are:

1. To develop an adequate "inner" life with capacity to cope, to translate, and to process the outside world.

   Here we are talking about the "ego", the internal language system, the cognitive processes, the mysterious inside-the-head system that directs our perceptions of the world in which we live.
2. To develop skills to relate to, deal with, and enjoy adults and children.

   Here we refer to interpersonal relations skills as the prerequisites for social activities; how to greet and chat with people, deal with stress and problem-solving, negotiate and have dialogue, actively plan and participate in age-appropriate activities.
3. To be competent at living; to do schoolwork, play games, and occupy oneself.

   The need expressed with this last goal is for the child to see himself as a "good-kid", a competent person. The child needs to be able to take care of his own basic needs, to dress, eat, go to bed, get off to school. The child must be able to identify with a peer group, share common school experiences and perform at a level he can perceive as O.K. in relation to peers. The child needs to be able to play games, hit the ball, have fun, be able to lose, be able to structure his own time and activities.

The child mental health specialist must be able to identify, program for and implement activities in all of the above goal areas. This person must have skills in the following three general areas:

1. Nurturing and being a parent model; active caring for and about the child.

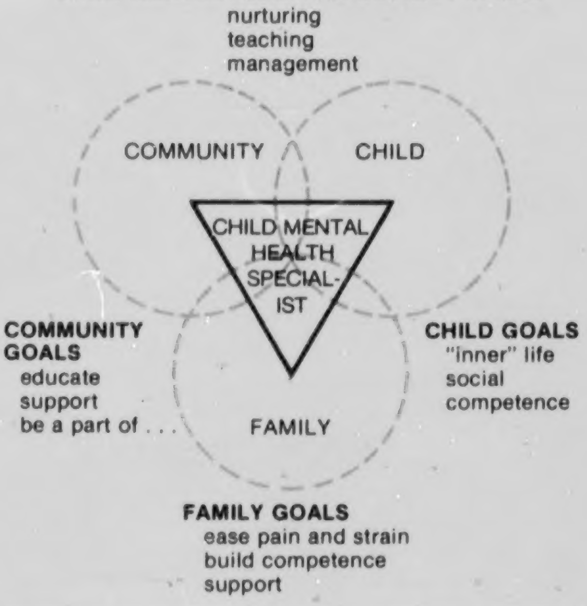
   The specialist needs to behave in a loving and affectionate manner, must communicate acceptance and caring, and must advocate for the child's as well as the family's best interest.
2. Special education; task analysis, academic assessment, teaching basic skills, individual counseling.

   The specialist has to know how to teach basic academic skills, how to program learning activities, how to identify needs, and to structure and sequence materials.
3. Child management and group care; concerned with limit-setting, stimulus arrangement, application of consequences, observation, data collection and evaluation.

   The specialist must be able to manage children individually, as well as in groups, set limits and deal with extreme limit testing, manage abusive and acting-out children, take data, chart, and evaluate.

The need, as stated earlier, is to develop a professional role which has pivotal responsibility for the primary life components for a child. General goals for the child have been briefly outlined. Basic skills of the mental health specialist proposed to provide the pivotal function have been outlined. Superimposed on those skills, in addition to the child need, are the community's goals and the family's goals. Diagramatically, the conception must include the outer parameters of the child's world and be centered in a skilled professional specialist.

CHILD MENTAL HEALTH SPECIALIST SKILLS



CHILD MENTAL HEALTH SPECIALIST SKILLS

Nurturing—being a parent model; active caring for and about the child.

Teaching—special education; task analysis, academic assessment, teaching basic skills, individual counseling.

Management—child management and group care; concerned with limit-setting, stimulus arrangement, consequate, observe, collect data, evaluate.

THE CHILD GOALS

Inners—to develop an adequate "inner: life with capacity to cope, to translate and process the outside world.

Social—to develop skills to relate to, deal with, and enjoy adults and children.

Competence—to be competent at living; to do schoolwork, play games, and occupy oneself.

FAMILY GOALS

Ease Pain—immediate behavioral first aid, family training, video feedback.

Competence—teach parenting, build self-esteem, family counseling

Support—family therapy, political education, child and individual advocacy.

COMMUNITY GOALS

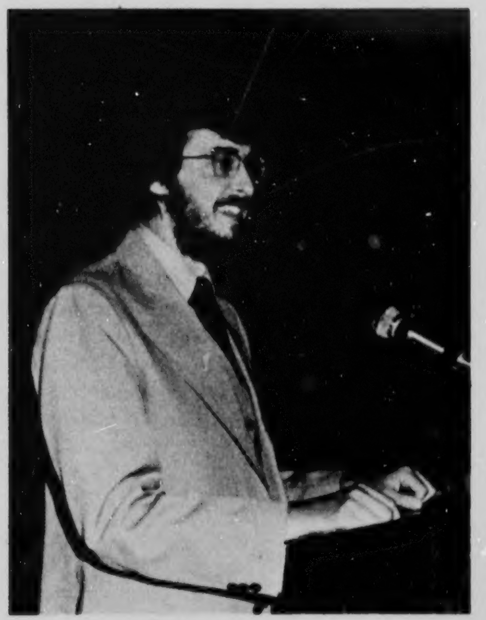
Educate—to needs of "our" children and to orient the child to community standards.

Support—increase tolerance for deviance, guide and educate.

To be a part of . .

The continued development of the professional child mental health specialist job function is dependent on the growing integration and collaboration of training programs and the continued focus on functional analysis of problem behavior. We must reinforce this thrust and maintain a clear and singular orientation toward a multiskilled professional who sits smack dab in the middle of the child's action.

In summary, The Child Center is a small community-based, re-education placement which may be viewed as the appropriate alternative to public school for some children. Our agency, and others like it, has a place on the continuum in offering a full range of options to seriously emotionally disturbed children and their families.



The Rutland Center—Developmental Therapy Model: A Practical Model for Emotionally Disturbed Children

Anthony Beardsley

Since the design and implementation of exemplary service models within the states is the major goal of our conference, I want to describe to you the development, operation, and curriculum of an actual model, the Rutland Center—Developmental Therapy Model Project. My remarks are drawn from 6 years of direct experience in providing services to severely emotionally disturbed and multi-handicapped young children. Most recently I was responsible for supervising staff development at the various regional centers of the Georgia Psychoeducational Center Network. Presently I am the Director of the Rutland Center National Technical Assistance Office, a technical assistance facility funded by the Bureau of Education for the Handicapped, USOE, under the Handicapped Children's Early Education Program. The function of this office is to stimulate increased services to seriously emotionally disturbed preschool children (ages 2 to 8 years with emphasis on children 6 years of age or younger), their parents and their teachers.

In this paper it is my intention:

1. to stress the importance of discretionary funds which make possible projects such as the Rutland Center Model;
2. to present an historical overview of the model's origins and evolution;
3. to discuss the way in which the National Technical Assistance Office at the Rutland Center disseminates information about the project and aids in its replication; and
4. to suggest some reasons for the model's success.

The Importance of Discretionary Grant Programs

The Rutland Center—Developmental Therapy Model Project came into being largely because of the Education of the Handicapped Act, Public Law 93-380. Through the federal discretionary funds it provides, this act encourages the design of comprehensive service delivery models which in turn can lead to state programs highly successful in meeting the needs of emotionally handicapped children. In addition to the discretionary funds available in P.L. 93-380, the State Education Agency discretionary allocations in P.L. 94-142 offer administrators important resources for model building and eventual service expansion.

The Rutland Center Model: An Historical Overview

To illustrate the impact discretionary funds can have, let me trace the effect of a demonstration project in Georgia from 1970 to the present. Consider the conditions at that time in Georgia. A fact sheet (found below) used in 1970 to alert state legislators and citizens to the crisis in services for emotionally disturbed children included the disturbing news that only 10% of Georgia children (0-17) needing special aid were receiving professional help with their serious emotional and behavioral problems. Please note that while Georgia has improved upon these conditions significantly, there are many other states in the nation whose situation today is much the same as Georgia's was in 1970.

Because of the appalling lack of services to emotionally disturbed children, a model project was designed as a community based program of psychological and educational services to children with severe emotional problems. The project was called the *Rutland Center—Developmental Therapy Model* and was designed to serve handicapped children from birth to age fourteen in a ten county area in Georgia. At that time, Georgia had no programs or plans for services to preschool children. Therefore, the project design was separated into preschool and school age components. The preschool component was submitted to the Bureau of Education for the Handicapped and subsequently funded. In three years it became a validated model for national dissemination, approved by the United States Office of Education, National Institute of Education, Dissemination and Review Panel.

FIGURE 1. Fact Sheet Prepared to Stimulate the Interest of Legislators and Citizens in the Critical Need for Services in 1970

DID YOU KNOW THAT:

- 30,300 Georgia Children (ages 0-17) need help with their serious emotional and behavioral problems.
- only 10% of Georgia children (0-17) needing special help are receiving professional help with their serious emotional and behavioral problems.
- only 124 preschool age (0-7) children having serious emotional and behavioral problems were served in 1970 and this represents 2.0% of those needing services.
- 95,584 children were born in 1970 in Georgia; 2,150 (2.25%) will have serious emotional and behavioral problems by the time they enter school.
- of the eight major residential institutions sponsored by the State of Georgia for mentally retarded and emotionally disturbed children and/or adults, only four offer services specifically for children with problems of behavior disorders or emotional disturbance.
- only 8 of 63 psychiatric outpatient clinics in the State of Georgia serve primarily child populations.
- 75% of children receiving services from outpatient psychiatric clinics are receiving such services from predominantly adult-oriented clinics.
- 25% of the children receiving treatment from outpatient psychiatric clinics received such treatment from predominantly child-oriented clinics.
- Central State Hospital has 1 1/2 times as many mentally retarded children in residence as it has behaviorally disordered and emotionally disturbed.
- of the 291 emotionally disturbed and behaviorally disordered children (0-17) at Central State Hospital, only 62 (21%) participate in a Special Education Program both because of a lack of teachers, and a lack of funds.
- only 41% of the emotionally disturbed children (0-17) at Central State Hospital are housed in "child-only" wards.
- the eight residential institutions sponsored by the State of Georgia treat 9 times as many mentally retarded as emotionally disturbed children.

The school age component of the model was funded for demonstration in 1970 by the Georgia General Assembly with state funds made available to the Georgia Department of Education. Both components began simultaneously and were developed as a unified program. During the three years of model development (1970-1973) BEH granted $307,460 for the preschool component (P.L. 93-380) and the State of Georgia $750,000, for the school age component.

The original proposals included as an objective the establishing of satellite centers in other areas of the state. The idea was to provide answers to the questions that state legislators were asking, "Does it work? What does it cost? Will it get the job done in other parts of the state? What you are doing is great, but will it work anywhere else? Can others do it with as much success?" In short, documentation of child progress, replication, demonstration, dissemination, and staff training were major concerns from the beginning.

As noted above, the need for services was incredible. The fact sheet was circulated to citizens state-wide who were involved in the Mental Health Association. It was also circulated to key state legislators. Perhaps most important, this sheet was part of a report prepared by the project staff and submitted to a special group appointed by Governor Jimmy Carter and called "The Governors Commission to Improve Services for Mentally and Emotionally Handicapped Georgians". This report represented the beginning of actual support from the Governor, state legislators, and concerned citizens.

By spending many, many hours talking to groups and individuals throughout the state, thirteen guidelines emerged as the basis of a state plan around which concerned agencies, groups, and individuals could rally. These guidelines also served as the basis for developing the Model Project which eventually became the prototype for the Georgia Psychoeducational Center Network.

1. The program should clearly distinguish mental health services for children from services for adults.
2. The program should reduce the need for hospital and residential care for young children by keeping children with their families while receiving services.
3. The program should serve children from birth to age 14.
4. The program should keep families actively involved in supportive ways.
5. The program should keep these children, whenever possible, enrolled in regular school or preschool programs while receiving these special services.
6. The program should serve children whose problems are severe and for whom no program or service is available.
7. The program should have the qualities of both educational and mental health programs.
8. The program should draw together available professional staff from mental health and special education.
9. The program should utilize paraprofessionals, volunteers, parents, and other community resources in the rehabilitative process.
10. The program should build upon existing agencies.
11. The program should permit counties to share services.
12. The program should apply to all of the rural and urban areas of the state.
13. The program should include a system for ongoing evaluation of treatment effectiveness.

The development of this plan required a staff sensitive to local conditions. In each mental health region of the state, a site was proposed which was the most central, urban location in the area. Each center then established a a series of rural outposts reaching into the surrounding counties. This was the beginning of the Georgia Psychoeducational Center Network. Currently, this Network is fully developed and serves the entire state, with 24 major centers and numerous rural outposts. In the year 1976-1977, over 7492 seriously emotionally disturbed children and their families received services. It is important to note that since 1974 the funding for the Network has been entirely supported by State dollars. The 1977-1978 line item grant for the Network is $5,727,467 plus 174 special education teachers assigned to it. (See diagram below.)

The National Technical Assistance Office

ASSISTANCE IN IMPLEMENTING THE MODEL

As the Georgia Psychoeducational Center Network steadily evolved, so did plans to carry the Rutland Center concept outside of Georgia. The National Technical Assistance Office took responsibility for the outreach effort. Through this autonomous affiliate of the Rutland Center, resources are now available to stimulate new and existing programs to use the Developmental Therapy model. Interested programs can receive four types of assistance:

1. A variety of publications and audio-visual packages explaining the approach;
2. Assistance in program planning and design, including needs assessments, selection of model components, cooperation with other agencies, and budget consultation and development;
3. Staff training including identification and referral process, intake and diagnostics, developmental therapy curriculum, school liaison, parent services, and staff evaluation;*
4. Assistance in establishing an effective evaluation system for the program itself, assessment of a program's present use of the model, recommendations concerning continued use, and the evaluation of technical assistance services.

IMPACT OUTSIDE OF GEORGIA

As a result of the National Technical Assistance Office's outreach efforts, dramatic results have been achieved in establishing the Rutland Center Model in other states. A total of 1448 preschool handicapped children previously unserved or underserved outside of Georgia receive services at 53 separate sites. An additional 897 preschool handicapped children were served in 40 programs reporting use of the model but not requesting outreach assistance. Perhaps even more important, for each dollar BEH/HCEEP invested in this outreach effort ($354,955) a return of $3.25 state program dollars was realized from 13 of the sites outside of Georgia. It is important to note that this local contribution was not required by law but was a condition of the outreach design for agencies seeking to receive the outreach service.

Why the Rutland Center Model is Succeeding

There are certain lessons to be learned from the Rutland experience. Many factors led to the Rutland Center Model's success. The most important of these were two decisions made early in planning. First, minimum use of Model Project guidelines was required for any new center, but considerable local choice was encouraged in selection of the curriculum treatment methods, type of infant services, and services to parents. In this way each new site could develop a program responsive to its particular local conditions. Perhaps this decision was the most important one made.

Of almost equal importance was the decision that each center use certain basic program evaluation procedures and staffing patterns. This made it possible to monitor not only each center's effectiveness but also the effectiveness of the total Network effort. Without a careful and systematic method of evaluation, the model could never have been convincingly presented as a solution to the problems of emotionally disturbed handicapped children. The evaluation system was one of the most reliable ways of determining that this was indeed a Model Project with a demonstrable impact.

Four other factors played major roles in the development of the Model. Without discretionary funds for model projects from the national level, there would have been, of course, no model in the first place. Without the training programs of the University of Georgia College of Education which provides continuing manpower to implement this new model, it would not have been as likely to succeed. Without the local communities' awareness of their need for such an innovative program, the Model Project would never have been adopted. Finally, without the support and interest of state legislators, the Governor, and the Georgia Department of Education, the model would have been limited to preschool children. This would have been a great loss. As the model now exists, concurrent programs for preschool and school age children ensure continuity of service. This means that a child entering at a preschool age and needing to continue services can do so without any abrupt change in service delivery or treatment style.

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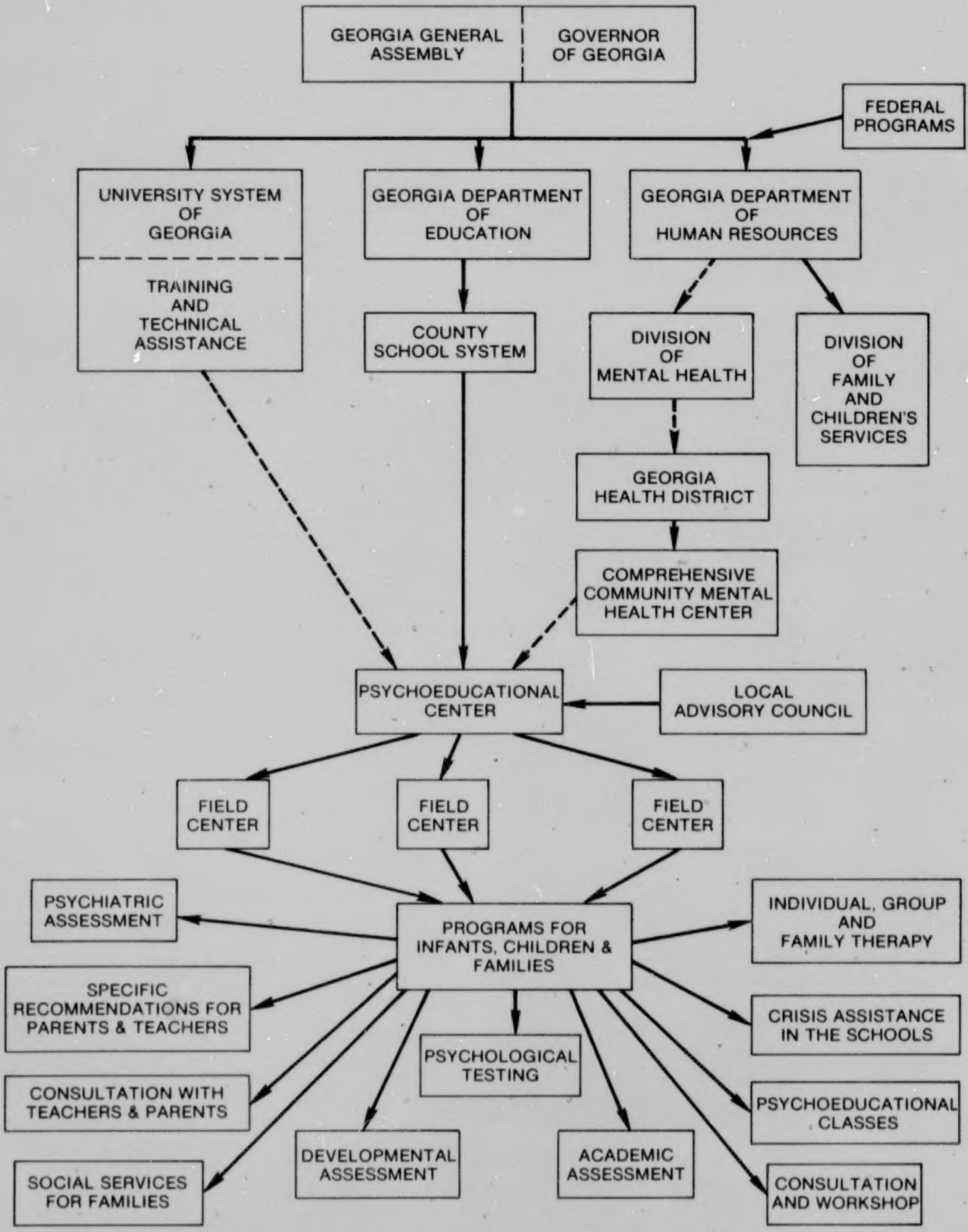
*Special institutes are offered throughout the year in collaboration with the University of Georgia to prepare supervisors and trainers in Developmental Therapy.

FIGURE 2. Agency Linkage for Administration of the Georgia Psychoeducational Center Network


GEORGIA GENERAL ASSEMBLY
GOVERNOR OF GEORGIA
FEDERAL PROGRAMS
UNIVERSITY SYSTEM OF GEORGIA
TRAINING AND TECHNICAL ASSISTANCE
GEORGIA DEPARTMENT OF EDUCATION
GEORGIA DEPARTMENT OF HUMAN RESOURCES
COUNTY SCHOOL SYSTEM
DIVISION OF MENTAL HEALTH
DIVISION OF FAMILY AND CHILDREN'S SERVICES
GEORGIA HEALTH DISTRICT
COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTER
PSYCHOEDUCATIONAL CENTER
LOCAL ADVISORY COUNCIL
FIELD CENTER
FIELD CENTER
FIELD CENTER
PSYCHIATRIC ASSESSMENT
PROGRAMS FOR INFANTS, CHILDREN & FAMILIES
INDIVIDUAL, GROUP AND FAMILY THERAPY
SPECIFIC RECOMMENDATIONS FOR PARENTS & TEACHERS
CRISIS ASSISTANCE IN THE SCHOOLS
PSYCHOLOGICAL TESTING
CONSULTATION WITH TEACHERS & PARENTS
PSYCHOEDUCATIONAL CLASSES
DEVELOPMENTAL ASSESSMENT
ACADEMIC ASSESSMENT
SOCIAL SERVICES FOR FAMILIES
CONSULTATION AND WORKSHOP

I would like to look briefly at this final point, concurrent programs for preschool and school age children, in more detail. It has been our experience that treatment of handicapped *preschool* children is *essential* to the successful treatment of older, school age children. The situation facing many states today is different than that faced by Georgia in 1970. Then there were no federally mandated programs for either the preschool or school age emotionally disturbed handicapped. The Rutland Center received federal monies for the preschool component of its model project while the state of Georgia voluntarily provided funding for the model's school age component. Thanks to P.L. 94-142 the states now have mandated programs for the school age handicapped. However, that law did not require preschool programs, and the extension to the law under present consideration urges but does not require states to institute preschool service. Part B, Section 619 of the extension to P. L. 94-142 provides a $300 incentive grant per child to encourage states to serve preschool children. Unfortunately, such grants simply do not supply enough of a stimulus to motivate the states to establish programs. I note in passing that the State of California, for example, grants public school systems $3,000 per autistic child.

In closing let me note that if the states do not voluntarily institute programs for handicapped preschoolers, their mandated programs for handicapped school age children will not function as effectively as might otherwise be the case. It can be said with certainty that the majority of preschool handicapped children in this nation are not receiving necessary services. It is reported that only 30% of the preschool children in need are being helped. This means that at the time in their development when the greatest portion of personality and cognitive skills are forming, preschool handicapped children are receiving little, if any, special assistance. There is no doubt in my mind that this is why we see so many handicapped children who fail to reach their individual potential with intervention beginning after age six. In addition to missing the therapeutic advantages of early intervention, states choosing not to establish services for the preschool handicapped population exclude themselves from meaningful interaction with the various validated Model Projects. This means they often do not benefit fully from the new model developments, additional personnel resources, and research such models produce. Therefore, fully funded services for handicapped preschool children from birth on are absolutely essential.

These materials were compiled by Michael Hendrick from a number of sources including:

William F. Pierce, Commissioner, Bureau of Education for the Handicapped "Statement Before the Subcommittee on Handicapped, Committee on Human Resources." United States Senate: March 22, 1977.

William W. Swan, *Outreach Assistance for Utilization of the Rutland Center—Developmental Therapy Model: 1973-1976 Three Year Final Report*. 1976.

M. M. Wood, "A Case Study in Replication," in *Outreach Replicating Services for Young Handicapped Children*, L. Gunn, editor. Technical Assistance Development System: University of North Carolina, Chapel Hill, 1976.

M. M. Wood, editor, *Developmental Therapy: A Textbook for Teachers as Therapists for Emotionally Disturbed Young Children*. University Park Press: Baltimore, Maryland, 1975.

M. M. Wood, editor, *The Rutland Center Model for Treating Emotionally Disturbed Children* (2nd ed.). National Technical Assistance Office: 698 N. Pope Street, Athens, Georgia, 1972.

Involving Parents of Severely Emotionally Disturbed Children in the Treatment Process

Richard L. Simpson, Ed.D.

My intent this afternoon is to share with you some of the ways in which we have been able to cooperatively and effectively work with parents of severely emotionally disturbed children and to argue the case that programs for the severely emotionally disturbed cannot adequately operate without parental involvement and support. My purpose in providing this information is not to suggest that we have found "The answer" nor that we will not continue to encounter failures with parents, but rather to share some experiences that we feel are quite exciting and potentially valuable.

So that you might more easily identify with my perspective, let me briefly describe the program that I am associated with. The Severe Personal Adjustment (SPA) Project is a program designed to serve the educational and social needs of severely emotionally disturbed children and adolescents in a public school environment. The project, which is being funded by the Bureau of Education for the Handicapped, is a joint venture between the University of Kansas Department of Special Education and the Kansas City, Kansas Public Schools.

The purposes of the project are to: (1) serve the needs of non-residentially placed emotionally disturbed students who cannot be easily integrated into existing facilities for the behaviorally disordered because of the severity of their handicapping condition; (2) to provide a model program for demonstrating procedures found to be effective with severely emotionally disturbed children; and (3) to disseminate these procedures found to be effective with severely emotionally disturbed children in such a manner that they can be implemented and replicated with similar populations in other geographical areas.

The educational program, a behavioral prescriptive model, is being implemented by two master's level teachers, two paraprofessionals, and an occupational therapist. This primary staff is being supported by special services staff from the Wyandotte County (KS) Special Education Cooperative. In addition, to provide further support, the program has on staff a project director, program manager, director of training, parent-home counselor, and a secretary. As you will note, ours is a public school program for autistic and autistic-like students who have in the past been denied access to the public schools or who have been given inadequate and/or inappropriate services because of the severity of their handicapping condition. Our over-riding philosophy is that in instances where parents desire to maintain their severely emotionally disturbed children and adolescents at home, we have a responsibility to provide an appropriate public school educational environment and direct parental support. I wanted to provide this description so you can identify with my frame of reference and my forthcoming comments.

I suppose each of us in our own way is quite cognizant of the importance of becoming involved with parents and of getting parents on our side. In fact, with parents and power groups composed of parents, federal legislation and other pressures, it is becoming increasingly clear that we not only need to establish rapport with parents, but that they need to be an integral part of our program. Public Law 94-142, as we are all well aware, in fact mandates that parents will be involved (if they so desire) in formulating the treatment program for handicapped children. Since many of us seem to learn more from our mistakes, we might also recall some of the ways we have probably alienated parents while working in the schools. One story that I like to tell is about a child by the name of Opium Jones, who was a black student in an elementary class that I instructed. While taking attendance the first day of class, I suspiciously came across the name "Opium Jones". When I quizzed this student about his name, he insisted that "Opium" was not a nickname, but rather "the only name I have". I of course was not going to be taken in by this, and I concluded that the child had a more "appropriate" name and that I would discover what it was. Sometime later, I had the opportunity of visiting with the child's mother at her home, and among other things, we talked about her son's name. When Mrs. Jones indicated that "Opium" was her son's "proper" name, I inadvertently blurted out "but opium is a dope". After apologizing for this verbal error, I tried to make my point again by saying "but you don't understand, opium is illegal". Obviously, this didn't help the situation, and in a final effort to explain myself, I said "but you don't understand, opium comes from a white poppy". As you might guess, that final response was not particularly effective in establishing rapport either!

More and more professionals given the task of educating emotionally disturbed children are agreeing that parents need to be involved in the intervention process and that educators have a responsibility to provide parents support. In fact, educational literature is replete with evidence that parents can be an important link in the treatment process and that they can be useful in promoting better adjustment in school. Unfortunately, the same literature indicates that we are relatively inefficient in our use of this resource. There is some relatively convincing evidence that many parents of exceptional children want to help in dealing with problems and in the education of their youngsters. Unfortunately, many of these individuals are quite frustrated because they don't know what to do; they want to work for the benefit of their child but they simply don't know the best strategy to employ. It's quite apparent that educators (and professionals in general) in many cases, are not providing the right kind of guidance to channel these motivations that many parents have. It is at least conceivable that many of those behaviors in parents that we as professionals complain about the most are those which we are bringing about ourselves. It might just be that because we are not able to channel the motivations that parents have, they are channeling their frustrations in other directions. For example, one of the things that professionals say that parents are too involved in is the non-functional area of labeling. Labels such as dyslexia, MBD, primary reading disorder, LD, hyperactivity, hyperkinetic behavior, apraxia, stimulus deprivation and ED are common words in the vocabulary of many parents. In addition, we complain that parents spend far too much time worrying about etiology (cause). For example, rubella during the first trimester, excessive weight gain, unresolved Oedipal complex, poor self-concept, early toilet training, late toilet training, permissiveness and structure have all been used to explain specific patterns of behavior. It just may be that we are seeing some of these behaviors because we are not providing parents with constructive things they *can* do.

It must be difficult for parents to read in *The Reader's Digest* or *National Enquirer* about specific problems (both academic and social) that their child might be having, followed by Marcus Welby curing a case of infantile autism in one hour (with time out for commercials) and then to read Ann Landers describe a Vitamin C cure for hyperactivity, and then to see their own child make very little progress in an approved program in which the parents have had little or no part.

Obviously, educators must adopt strategies that will allow for more effective use of parents of handicapped children as extensions of treatment. One of the initial procedures for enlisting the aid of parents of behaviorally disordered and socially maladjusted children is to conduct an initial interview session. The purpose of these initial conferences is designed to not only exchange information but to also establish rapport necessary for future cooperative efforts. There are also other forms of justification for the initial parent interview. Certainly one of the most prominent is related to the significant influence that parents play in the life of any child. It appears as if each of the advantages accrued from establishing and maintaining contact with the parents of exceptional children is based on the finding that parents do influence a child's ability to function in educational settings. Both subjective and empirical reports strongly support the findings that programs which have established parental support and programs which employ parents in a functional manner have a greater probability of realizing positive outcomes than programs which function with little or no parental involvement.

An additional justification for conducting an initial interview with parents of emotionally disturbed children is based on the positive effects that can be derived from early involvement. This initial involvement, especially if of a positive nature, has been shown to be in numerous cases a mechanism for increasing the probability of success with a child. Duncan and Fitzgerald (1969), for example, investigated the effects of establishing a parent school relationship prior to a child's entrance into junior high school. These investigators demonstrated that early positive parental contact significantly increased not only the amount of parental contact with the school but also the attendance, grade point average, drop-out rate and the number of disciplinary referrals of the children whose parents had the early involvement.

A third justification for conducting an initial parent teacher interview is related to the central nature of special education programs. Certainly one of the most apparent and easily defended reasons for holding an initial conference with parents of emotionally disturbed children is related to the fact that school, at least in many cases, is the first and only professional agency to reach all children. Special educational programs, by the very nature of their structure, have historically slanted many of their services towards children from impoverished and broken homes as well as towards minority groups. This being the case, it is apparent in numerous situations that the educator in a particular school or setting may be the sole professional to come into contact with all school age children. Since many special education children are not followed by physicians, psychologists, social workers or other professional personnel, it becomes obvious that if a child is going to receive an appropriate referral or if services are going to be designed to meet a child's special needs, then it is mandatory that the one professional person with whom a child has sustained contact have sufficient background information and sensitivity to the family situation to function as an advocate. In a practical sense, this requires that the educator function as a safeguard to assure that no child is denied appropriate services because of a lack of relevant information. Thus, the educator must function in such a manner as to solicit any and all information that may have a bearing on a child's ability to function in school, even if the information is not within the traditional confines of an educator's area of expertise.

Finally, a parent interview is necessary because of its central role in the pre-academic year planning of the educator. Obviously, pre-academic year planning for a seriously emotionally disturbed child should include a time for visiting with parents about the techniques and methods that will be employed. This phase of preparing for a child should not only include a discussion of possible reinforcers that will be employed and possible ways the home and school can cooperate, but also an opportunity for the educator to assess parental attitudes and in general to attempt to develop a sensitivity for the home situation. The initial interview from this perspective serves as an opportunity for the teacher to evaluate and analyze possible areas of conflict, which in many cases will serve as the major variable determining whether or not the teacher will be able to enlist the support of the parents. (See Interview Format below.)

FIGURE 1. Parent Interview Format

I. Identifying Information
II. Chief Complaint of the Parents and their perception of the reason for the child's placement in special education
III. Developmental History
    a. Prenatal factors
    b. Perinatal factors
    c. Neonatal factors
    d. Infancy factors
    e. Preschool factors
IV. Personality Characteristics
V. School History
VI. Parental Expectations
VII. Sociological Information

It has been our intention that the parents of the children involved in our program are an integral part of the treatment and education process and that the program cannot justify its existence without parental support. Since it is our contention that programs serving the emotionally disturbed without parental involvement can do little more than delay crisis situations, the parents of each child in our program are encouraged to indicate a willingness to participate in our program. Specifically, each parent is asked to sign a participation contract. We specify our willingness to make a committment to the child and the family and consequently we ask the parents to do the same. Although this contract is non-binding, it aids us in solidifying our commitment to the child and the family and in asking that the parents do the same with us. (See sample Parent Agreement Form below.)

The basic philosophical approach that is used by our staff in working with parents is behavioral. However, we are quite eclectic and frequently we employ humanistic, transactional analysis, and other approaches with our parents. Our feeling is that we should be open to a number of options and the neglect of certain areas, such as affective, can only be detrimental to the child's family and our program. Nonetheless, we have chosen to rely on a behavioral model as our primary problem solving strategy. Our rationale for adopting this approach was that it provided the parents of the children in our program with specific tools for dealing with some of the behavioral excesses and deficits of their children. We also perceived this approach to represent a logical and parsimonious means of extending the resources available to the children. Our approach was conceptualized, in fact, as an extension of Seymour Sarason's view of "professional preciousness", or the view that individuals other than "mental health professionals" can be potentially contributing members in the treatment process. It was our specific intention that by equipping parents with specific methods for ameliorating specific problem behaviors, our professional staff will be better able to circumvent the manpower dilemma.

In implementing our model, we have relied on several procedures which you may find somewhat novel. First, we have worked primarily on an individual basis with our parents. Although we gradually phase in more group work, it is our feeling that the initial needs of the parents are such that they are most amenable to a one-to-one process. It is our belief that we can most sincerely communicate our commitment to the child and the family and indicate our seriousness about the parents' participation if we work on a one-to-one basis.

We have also worked to a large extent with our parents in their own homes. Although we have modified this in some instances, and have based the site of the meetings on the desires of the parents, we have had very good success with this tactic. Again, this procedure helps to communicate our willingness to follow through with our commitment and to make the parents aware of their need to be involved. Although most of our parents have had many verbal commitments, few individuals or agencies have actually followed through.

Finally, we have made the assumption that to be effective with our parents we must do the following:

1. Provide information about what the future will be. This information has ranged from possible future

FIGURE 2. Severe Personal Adjustment Program

Parent Agreement Forms

The Department of Special Education at the Kansas University Medical Center and the University of Kansas cooperate with the Wyandotte County Comprehensive Special Education program in offering special class placement for emotionally disturbed children. Because these children present unique and difficult challenges, the educational program is also in many ways unique. The following is a list of program features on which we would like your help. Parents of prospective students are urged to read this list carefully. It is intended to give the parents a sample of some of the things expected of them. Full cooperation is essential to the participation and success of your child in the program. It is hoped that the parents will also communicate their expectations to the staff.

While the focus of the teacher and the staff is on the child, the parents are viewed as the final ingredient for success.

1. Various evaluations (e.g. medical, psychological, psychiatric, educational, etc.) may be scheduled for your child. Some of these evaluations must include information from both parents.
2. Parents are required to attend and participate in weekly individual or group meetings. A schedule of mutually convenient meeting/appointment times will be established by the Parent Counselor.
3. All students are provided with an extremely reasonable amount of daily work, along with success oriented expectations for completing it. Some of this work must be finished before lunch is served. However, for whatever reason(s) the specified work is not finished by the day's end and the student misses the school bus home, parents will be required to arrange transportation home for the child.
4. When deemed necessary by the staff, specific requests such as individual or family therapy according to needs will be made of parents.
5. Emergency numbers are required in order that parents or designated persons may be reached at any time for the following reasons: sickness or accident, transportation home from school, and extreme behavior problems.

Date ______________________

____

Signature of Parent-Counselor or other staff

Date ______________________

____

____

Signature of Parent or Guardian

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educational and treatment programs for the child after he completes school to the prognosis for normality.

2. It is necessary to respond to the parents' specific concerns. We have attempted to deal with those problems that are of greatest concern to the parents rather than nebulous and abstract concepts like changing attitudes, overcoming guilt, etc.

In establishing home management programs, we have employed specific procedures and communicate our model to parents through use of a plan sheet. (see figure 3 and 4 respectively at end of text.)

Examples

Perhaps I can lend some reality to the procedures that I have been talking about with the following illustrations:

CASE STUDY 1

This first case study is an illustration of the potential utility of a home-school communication program. The student was a severely psychotic sixteen year old who had a history of violent behaviors. Specifically, he periodically would verbally and/or physically threaten and attack his peers, teachers and parents. Since this aberrant behavior was grossly incompatible with public school placement, procedures were developed to decrease its occurrence. Since our desire was to provide the child's parents with meaningful information about his daily school performance, a multi-purpose reporting system was devised.

Included in the reporting were ratings on (1) compliance, (2) academic work, (3) self-control and (4) social interaction. Each of these categories was operationally defined and assigned a daily rating (5 = excellent; 1 = poor). The note was then sent home with the child to be given to the parents. The parents would then apply differential consequences, ranging from full privileges to none at all, based on the number of rating points received daily. Special rewards, to be exchanged on weekends, were held contingent on the youngster getting 80 or more rating points per week. The youngster's ratings quickly reached the maximum possible, i.e., 20 per day. Concommitant with the increase in ratings for the positive behaviors of following directions, academic work, self-control, and social interaction, there was an observable decrease in threatening behavior at school.

CASE STUDY 2

This student is an eight year old male who had previously been diagnosed as autistic and functionally mentally retarded. Although this child had developed a limited expressive repertoire, he frequently engaged in self-stimulatory verbal behaviors. This behavior, which at times occurred simultaneously with non-verbal self-stimulatory responses such as hand-flapping and head weaving, consisted of making repetitive sounds that were not designed to communicate. Although the child had been trained through a tightly controlled and individualized language program to express himself, he rarely employed spontaneous expressive language in instructional situations. Rather, if given the opportunity, he made a variety of repetitive sounds that had no effect on his environment.

To deal with this behavior in the classroom an overcorrection procedure was introduced. This consisted of the following:

1. *Verbal Warning Followed by an Overcorrection Procedure*
When observed to be engaging in self-stimulatory verbal behavior, the subject was told "no noise" in a bland tone. If he complied with this command within 1 second, no further action was taken. However, if he failed to observe the command within the allotted time, an overcorrection procedure was applied. This consisted of an adult applying his or her hand firmly to the subject's mouth and holding it there continuously for 30 seconds. The treatment, administered by an adult who stood behind the child while he was seated at his desk was applied with neutral temperament. At the end of the 30 second period, the adult applying the treatment said "good being quiet" and then moved his/her hand from the child's mouth. In the event that the child was attempting to make noises at the end of the 30 second period, the adult's hand remained over his mouth until he was quiet.

FIGURE 3. Specific Procedures for Establishing a Home Management Program

OBJECTIVES	ACTIVITIES
(1) Pinpoint and define behavior (operationally)	• List and objectively define the family's major behavioral concerns about child's behavior • Rank order those concerns from highest to lowest. • List and objectively define the child's positive, adaptive and desirable behavior. • Select one behavior of critical importance to the family. Caution: Probability of success is a prime factor in selecting behavior for change.
(2) Evaluate situations and environments in which the behavior occurs	• Evaluate the situations, environments & circumstances under which the target behavior usually occurs.
(3) Specify contingencies presently operating	• Evaluate the reactions of the parents and others after the problem behavior is emitted.
(4) Observe & record target behavior daily	• Describe simple recording system and corresponding recording sheet. • Observe and record target behavior using system and appropriate data sheet on a daily basis. • Reliability check on target behavior between parents and parent counselor to clarify both the nature and magnitude of the problem. • Make necessary adjustments in behavior definition or recording procedures.
(5) Chart & inspect target behavior data	• Devise simple visual displays (charts) for target behavior. • Record daily observations on charts. • Inspect data for variability and trend before ending baseline period.
(6) Devise intervention plans and establish performance expectations	• Develop appropriate reinforcing & punishing contingencies for specific target behavior. • Ideally, interventions should be: Practical, Economical, Feasible, Realistic, Applicable and Effective. • Next, establish a desired rate (frequency/day) or goal for target behavior. • Establish a desired target date for the behavior & the respective desired rates. • Establish sequentially placed interim desired rates and dates for the target behavior.
(7) Implement plans	• Apply contingencies to target behavior using: Consistency, Constancy, Immediacy. • Observe & record target behavior daily.
(8) Analyze data	• Inspect target behavior with respect to desired rates and dates.
(9) Be prepared to make data based decisions in order to maintain/change intervention plans	• Suggest appropriate modifications for program maintenance or change.

Throughout the day, the correction procedure was employed.

2. *The overcorrection procedure described in number 1 was applied without a verbal warning.*

This procedure was effective in decreasing inappropriate verbalizations. At the same time, we observed a significant increase in appropriate language during formal training.

Since this procedure was effective at school, we *implemented it at home via the parents.* We also observed several positive and negative collateral behaviors at the same time. Again concommitant with the decreasing frequency of negative behaviors there was an increase in the frequency of positive behaviors.

FIGURE 4

Plan Sheet#____ *for:* ____________
Location: ____________
Managers: ____________

Aim	
A	
M	
D	

Behavioral Objective: Specify the behavior its direction and goal ____________

PROGRAM	INSTRUCTIONS	BEHAVIOR	HOW	WHAT
Describe the program: What, how, when, and who will conduct the program.	Describe what happens before and/or during each occurrence of the behavior.	Describe the behavior objectively so all can treat it in a similar manner and so an accurate record of it may be obtained.	Specify the relationship between the behavior and its consequences. (Ratio or interval arrangement.)	Describe "What" consequence is applied and by whom.
Plan Sheet for Henry		**Aim** A X M D	Behavioral Objective: to increase toy picking-up behavior to a 100% level.	
The program is to increase Henry's picking-up his toys behavior at bedtime. The program will take place at home on a daily basis and will be conducted by Henry's mother. (Date started)	At bedtime, the mother goes to Henry's room and announces, "Henry, its time for bed. Please pick up your toys."	Picking-up toys: Henry is to pick up each toy and place it in his toy box by himself.	1:1	Following each response, Henry is praised and hugged. Phrases like "Good picking-up, Henry" or "Good boy" are used.
		Non-compliance: Henry doesn't respond within 5 seconds of mother's request.	1:1	Henry's mother manual helps him respond.
				(Date started) Praise is used alone. No hugs.

This plan sheet is a modification of one developed at the Experimental Education Unit at The University of Washington.

Administrative, Logistical and Fiscal Considerations in the Implementation of CORBEH's Behavior Management Packages for the Remediation of Specific Classroom Behavior Disorders

Hill M. Walker, Ph.D.

The purpose of this paper is to provide school personnel with information concerning CORBEH'S behavior management packages that will facilitate their correct application and thereby increase the chances of obtaining desired outcomes. Brief descriptions of CORBEH and its service delivery system are provided initially. Specific descriptions of the behavior management packages are then provided along with the classroom behavior disorders each is designed to remediate. The research and development process leading to production of the packages is also discussed. Finally, administrative, logistical and fiscal considerations affecting implementation of the packages are discussed in terms of their impact upon the packages' effectiveness in producing desirable changes in child behavior.

CORBEH

CORBEH (Center at Oregon for Research in the Behavioral Education of the Handicapped) is a research and development center funded by the Bureau of the Handicapped, U.S. Office of Education. The center contracted in 1970 to develop, test and validate four behavior management packages for use by school personnel in remediating behavior disorders. A separate package is being developed for each of the following behavior disorders: (1) acting out behavior, (2) low academic survival skills, (3) social withdrawal and (4) social aggression.

SERVICE DELIVERY SYSTEM

The teacher consultant model has been selected by CORBEH as a vehicle for both the development of the packages and for their delivery to target children in classroom and playground settings. Teacher consultants, employed by CORBEH, play an instrumental role in the development, testing and validation of each of the packages. They serve a liaison role between CORBEH researchers who are responsible for developing the packages and the target children and their respective classroom teachers and/or playground supervisors who are the primary consumers of the procedures contained in the package(s).

Once the packages are developed and validated, teacher consultants, such as counselors, school psychologists, social workers, or resource teachers employed by school districts, are seen as the primary delivery agents for each of the packages. The consultant masters the behavior change procedures contained in the package via an intensive 2-3 day training workshop conducted by CORBEH personnel and then assumes responsibility for the following tasks (1) disseminating information about the packages to interested classroom teachers and/or playground supervisors, (2) assisting teachers/playground supervisors in the referral of appropriate candidates for the package(s), (3) explaining the package(s) to the classroom teacher, playground supervisor and other concerned school personnel, (4) explaining the program to the child's parents and obtaining their permission for their child's participation and their willingness to cooperate with it, (5) explaining the program to the child and to his/her classmates, (6) implementing the program in the classroom and/or in the playground and operating it effectively for a 5-10 day period, (7) training classroom teachers and playground supervisors to operate the program, (8) monitoring the program and providing the necessary consultative support and (9) coordinating the fading of program components and supervising the gradual termination of the program.

The teacher consultant is seen as the key social agent in the effective delivery of each package. Consultants have proven to be highly effective delivery agents in field testing and training activities carried out to date. Two important considerations affecting the performance of consultants in this regard are that (1) they must have or be able to establish an effective consultative relationship with the child's teacher(s) and playground supervisor(s) and (2) that they have the time available to implement the package effectively. Each package runs for approximately two months and requires 35-45 hours of consultant time over this period.

THE BEHAVIOR MANAGEMENT PACKAGES

The four behavior management packages under development by CORBEH are (1) The CLASS (*C*ontingencies for *L*earning *A*cademic and *S*ocial *S*kills) program for acting out children, (2) The PASS (*P*rogram for *A*cademic *S*urvival *S*kills) program for children with low academic survival skills, (3) The PEERS (*P*rogram for *E*stablishing *E*ffective *R*elationship *S*kills) program for socially withdrawn children and (4) The RECESS (*RE*programming *C*ontingencies for *E*ffective *S*ocial *S*kills) program for socially negative/aggressive children. The CLASS and PASS packages have been field tested and both are now completed. Negotiations with commercial publishers are currently ongoing for publication of these two programs. The PEERS and RECESS programs will be field tested in the 1977-78 academic year and will be completed near the end of 1978. Commercial publication will also be sought for these two packages.

The four packages are all designed for use primarily in regular classroom and playground settings. The packages are implemented over a 2 to 3 month period and then either terminated or followed up with a low cost variation of the intervention procedures designed to maintain the target child's changed behavior over the long term. Although designed for use primarily in mainstream educational settings, the packages can and have been used in special and resource rooms. However, efficacy studies of the packages have only been carried out to date in mainstream settings.

CLASS

The CLASS program is a set of procedures designed to modify the disruptive behavior of the acting out child. As noted, the program is intended for use in regular primary classrooms. However, the procedures, with minor modifications, can be implemented in a variety of classroom settings. Specifically, its goal is to increase the occurrence of those behaviors which are prerequisites for successful social and academic achievement and to decrease the frequency of behaviors that interfere with such achievement. To reach this goal, the CLASS program involves as many social agents as possible—parents, teachers, classmates—to build in positive behavior across multiple settings.

The program is implemented via a teacher-consultant, e.g., school psychologist, counselor, or resource teacher, who works closely with the regular classroom teacher. They provide direct intervention in the regular classroom setting, and when necessary, involve additional school personnel to extend the program to other school settings such as the playground, hallways, lunchrooms, and other classrooms.

The basic components of the CLASS program include: (1) the identification of a child likely to benefit from the program; (2) procedures for obtaining the involvement and cooperation of all principal participants; and (3) the implementation of the remedial procedures. Children are selected through teacher's ratings and classroom observations by the consultant. After the case is accepted, the program is explained to the child's teacher and principal, his parents, the child himself, and his classmates. Each party signs an agreement which specifies his/her role and responsibility in the program. The program does not proceed unless the agreement has been signed by all.

The remedial procedures are divided into two phases. Phase I (Days 1-5) requires the intensive in-class involvement of the consultant. Using a red/green point card, the consultant provides the child with continuous feedback as to the appropriateness (green side) or inappropriateness (red side) of his behavior. The consultant also praises the child and awards points which are exchanged for a reward shared by the entire class when a prescribed number of points are earned. Two successful periods in a day result in an additional reward and praise at home. During this time the teacher is increasingly involved.

Phase II (days 6-30) is characterized by a complete shift in program responsibility from the consultant to the classroom teacher. By Day 10, the program has been extended to the entire school day and Day 20 is the last day on which tangible rewards are used. By the end of the 30 Program Days, the teacher is well prepared to help maintain the child's new level of appropriate behavior using praise and rewards occurring naturally within the school environment.

To allow for individual differences, children who do not progress smoothly are recycled to earlier successful levels. Therefore, while the procedures require 30 program days, the successful completion of these 30 steps may take more calendar days.

The great majority of acting out children who are judged to be appropriate candidates for the CLASS program are males. The behavioral characteristics of such children often include one or more of the following (1) disrupting the classroom, (2) noncompliance with teacher instructions, directions and commands, (3) hurting others, (4) destroying property, (5) low levels of academic achievement and (6) teacher defiance. The behavior pattern of these children can be characterized as acting out against classroom rules, procedures and established structures.

PASS

The PASS program is a group behavior management system designed to increase the competence of primary level children on academic survival skill behaviors. Academic survival skills are the prerequisite classroom behaviors that are necessary for effective academic performance, e.g., attending to assigned tasks, listening carefully to teacher instructions and directions, following directions and talking with peers about academics. The PASS Program is designed to improve the skill levels of children in classrooms who have low rates of academic survival skills. However, the program is applied on a classwide basis to the behavior of all children in the classroom. Thus, low functioning children are not singled out by the PASS program as part of the intervention procedure.

The PASS program is designed to serve as a referral and in-service teaching tool for use by the consulting school professional, e.g., counselor, resource teacher, school psychologist, team leader, in-service instructor. It contains all the materials and procedures required to carry out a successful change program. Included are solutions to problem situations that frequently arise, suggestions for engineering the program to the idiosyncratic nature of most classroom programs, and alternative suggestions regarding situations in which the program would not be beneficial or appropriate for use. Research has shown that if the procedures and techniques are systematically and consistently applied, significant improvement can be expected.

The PASS program is established with the help of a teacher consultant in the regular classroom setting, and is managed by the classroom teacher. While the program involves all children in the classroom, its primary goal is to improve the academic survival skills and achievement of the children *most deficient* in these skills. The second major goal of PASS is maintenance of the program's effects after removal of the program's components.

Teachers are taught to use PASS in six two-hour in-service meetings conducted by the consultant during after-school hours. Specific objectives must be demonstrated by teachers in these meetings before their final implementation in the classroom. At each meeting, teachers (1) read a prepared unit of the Teacher's PASS Manual; (2) respond to a short, self-correcting quiz over the material; (3) discuss the material with the consultant, making applications and generalizations of the principles involved to the teacher's specific situation, and (4) roleplay skills learned earlier in the meeting before classroom implementation.

PASS is divided into five major classroom implementation phases:

1. *Preliminary assessment.* Preliminary observations are carried out by the consultant to determine the need and appropriateness of the program to the problem situation.
2. *Teacher baseline observations.* The teacher learns to record and graph the amount of time all the students in the class are demonstrating survival skills during one or two daily academic periods.
3. *The full program.* The teacher and consultant introduce classroom survival skill rules, group rewards using available school activities, and teacher social praise for improvement of the class survival skill score recorded by the teacher.
4. *Removal of the program.* Following initial improvement in the class survival skill level, the teacher begins a gradual removal of program components introduced in the full program.
5. *Maintenance of classroom survival skills.* The teacher carries out two random weekly checks on class survival skills and the teacher's praise rate. Three options are available for reinstituting the program to regain improved levels if maintenance checks indicate a drop in performance.

The complete program is in operation for 25-45 consecutive school days depending upon the rate of progress and the number of daily academic periods involved.

Children with low academic survival skills are not behavior problems in the same sense as are acting out children. They are not, as a rule, disruptive of classroom atmosphere nor are they usually defiant of teacher commands and directives. However, the types of inappropriate classroom behavior(s) they frequently engage in are incompatible with academic performance and achievement. As a result, such children are often below grade level in achievement. The ratio of males to females low on academic survival skills is approximately 6.5 to 3.5 in favor of males.

PEERS

Like the CLASS program for acting out children, the PEERS program for socially withdrawn children utilizes an individual contingency with group activity rewards shared equally with classmates. That is, target children in the PEERS program earn a daily group reward in which all peers share. This contingency procedure has several advantages in that (1) it motivates a target child's peers to be supportive of and cooperative with the intervention program and (2) it in no way teaches the child's peers to be deviant in order to be treated in a special way, e.g., reinforced, since they share equally in all rewards that become available. Since the PEERS program is concerned with social interaction and social interactive skills, the playground rather than the classroom is the primary intervention setting because it provides an excellent set of stimulus conditions for improving children's level of social competence. The PEERS program is also concerned with building in skills and competencies rather than reducing levels of child behavior considered to be inapproprate and/or disruptive. Thus, while some CORBEH behavior management packages, of necessity, contain procedures for decreasing inappropriate child behavior (CLASS, RECESS), the

PEERS program for socially withdrawn children is concerned only with skill acquisition and with building in effective performance in the area of social functioning/competence. Consequently, techniques for producing behavior change in the PEERS program consist of direct instruction prompting and positive reinforcement procedures—all of which are designed to increase levels of appropriate child behavior.

The PEERS program consists of four major components. These are (1) Social Tutoring or Coaching, (2) Joint Task, (3) Recess Point System with Backup Rewards and (4) A Verbal Self-Report Procedure. The coaching procedure and the Recess Point System are the major responsibility of the consultant—the other procedures are implemented by the classroom teacher. However the consultant is also responsible for insuring that the teacher carries out these procedures correctly. The PEERS program requires from 20-40 school days for implementation. The consultant is involved for a minimum of 20 days, but the specific number of days is actually determined by the individual target child's performance.

On program Day One the intervention procedures begin with the first of three Social Tutoring or Coaching lessons. Also on Day One, the teacher, under the supervision of the consultant, organizes the first Joint Task activity in the classroom. Day Two is much like Day One except that the child is interviewed by the teacher and consultant who attempt to enlist his/her active participation in the program.

On Day Three, several major components are added, e.g., the Point System is introduced to the class and implemented in one specified recess period with the Verbal Correspondence procedure, which requires the child to report to the teacher about her/his play activities after each recess period, introduced in the remaining recess periods. Simultaneously, joint task activities are introduced to the target child and his/her peers within the regular classroom setting.

Except for the coaching component, which terminates after three days, the entire program (including joint task, recess point system and verbal correspondence) continues for the duration of the intervention period. When the target child's level of social behavior is found to maintain at or above the criterion level for his/her grade level, then a gradual withdrawal of the components is initiated. The fading procedures continue until all of the components have been removed.

Implementation of the recess point system is the major responsibility of the consultant. The teacher is involved in introducing it to the child and to the class. Thereafter, s/he is responsible for a brief setup before recess and for arranging the group reward activity which follows each time the child meets the daily criterion. The consultant operates the daily recess point system and engages in the following tasks: (1) prompting and praising the child and his/her peers, (2) recording child behavior and (3) awarding points for all forms of social behavior. The target child and his/her peers are involved in the selection of daily activity rewards, e.g., classroom games, extra recess, free time, etc. A different reward is made available for each day that the reward criterion is achieved.

The recess point system is implemented in only one recess period each day. A verbal self-report or correspondence procedure is implemented both in the recess period in which the point system is operating and in all other recess periods. This procedure is designed to stimulate generalization of treatment effects to non intervention settings and to encourage the child to talk about his/her social interactions. This procedure may increase the child's chances of maintaining social interaction gains after the program ends.

Joint Task is the primary responsibility of the classroom teacher with the consultant assisting. Joint Task is a shared activity, between the withdrawn child and a peer, which requires turn-taking and verbal interaction, e.g., flash card drills. The level of verbal interaction required is determined by the structure of the Joint Task and is increased as the child's success with each level of verbal interaction increases.

The major purpose of the Joint Task is to structure opportunities for the socially withdrawn child to interact with her/his peers in a classroom setting on a daily basis over an extended period of time. Each day, the teacher assigns the withdrawn child to work on a Joint Task activity with a different peer.

Joint Task occurs daily and requires 10 minutes of classroom time. The teacher is free to schedule the Joint Task activity anytime during the school day. Joint Task involves the child and one peer. The teacher selects a different peer each day from the class list until each child has been chosen at least once. In this way, the child has the chance to interact in the Joint Task setting with each peer in the classroom.

Joint task is valuable in that it systematically exposes the withdrawn child to each member of her/his peer group through a shared classroom activity. It elicits turn taking, cooperative behavior and verbal responding. It can also serve as a priming device for social interactions that may subsequently occur either in the classroom or on the playground.

Children for whom the PEERS program was designed have extremely low rates of social contact with their classmates. They may also be isolated in a sociometric sense but their rate of social interaction with other children is the primary selection criterion used to determine their appropriateness for the PEERS program. The reasons for their low rates of social interaction are not always clear. It is possible that many of these children have not learned the social skills that are necessary for initiating and maintaining positive social relationships with their peers. It's also possible that the children's interactive behavior is not under

30

stimulus control of naturally occurring reinforcers for such behavior in playground and classroom settings. Whatever its antecedent condition(s), it's apparent that social withdrawal can be a very serious obstacle to a child's development.

The ratio of males to females who are judged acceptable for the PEERS program is approximately even or slightly in favor of females. This is in marked contrast to the other three packages wherein the ratio is clearly in favor of males.

RECESS

The RECESS program for socially negative/aggressive children also uses an individual contingency with group activity rewards shared equally by the child and his/her classmates. A daily group reward is available whenever the criterion is achieved. The child can also earn individual home privileges and rewards, on a concurrent basis, for performing well in the program at school. This dual school and home contingency arrangement increases the likelihood that a meaningful source of reinforcement will be identified for each child who participates in the program.

Like the PEERS program, the primary focus of the RECESS program is upon social interaction. However, for withdrawn children, their problem is primarily one of level of social interaction; in contrast, the concern with socially negative/aggressive children is with the quality of their interactive behavior. The primary treatment setting for the RECESS program procedures is the playground where new patterns of interactive behavior can be taught and developed. Because socially negative/agressive children often break classroom rules, are sometimes disruptive of classroom atmosphere and have difficulty cooperating with classmates, it is necessary to extend the RECESS program to the classroom setting in many cases. Procedures are built into the RECESS program for accomplishing this task.

The RECESS program consists of the following components: (1) discrimination training for the target subject and his/her peers in appropriate versus inappropriate social behavior, (2) a response cost point system in which previously awarded points are subtracted for inappropriate social behavior and/or classroom behavior, e.g., rule breaking, (3) adult praise (consultant, teacher, playground supervisor) for positive, appropriate interactive behavior and (4) concurrent group and individual reniforcement contingencies with the group reward available at school and the individual reward available at home. The point system, praise, and school and home contingencies are in effect throughout the entire program. The discrimination training procedures are implemented just prior to the start of the program with review sessions programmed intermittently during its early stages.

The RECESS program consists of four sequential phases occurring over a 6 to 7 week period. These are (1) Recess Only, (2) Full Program, (3) Fading and (4) Maintenance. The Recess Only part of the programs lasts two weeks and the consultant assumes primary responsibility for operating it. The intervention procedures are implemented in all three recess periods simultaneously and if the target child has zero negative/aggressive behavior in 2 out of the 3 recesses, the daily group reward is earned and made available at the end of the school day. Whatever recess points remain at the end of the day can be exchanged for tickets which are taken home to count toward special home privileges. During this two week period, the consultant gradually trains the recess supervisor(s) to operate the program and transfers control of it to them.

Once the playground supervisor is running the program smoothly and effectively, the consultant begins making arrangements to extend the program to classroom areas. The extension occurs via a procedure in which the target child must earn access to each of the three recess periods during the day. In order to earn access to recess, the child must follow classroom rules and be polite and cooperative with other children and the teacher. Unless access is earned to at least two daily recesses, the school group reward cannot be earned.

Once this portion of the program is operating effectively, fading procedures are introduced. Initially, the consultant's program monitoring activities are reduced from a daily basis to approximately twice per week. Next, fading of major program components is begun. Initially, the daily group reward at school is eliminated with the recess point system and home backup rewards retained. A bonus reward is available at school approximately once per week if the child's performance continues to maintain. The point system and home rewards are terminated next. Adult praise in both playground and classroom settings is continued.

To build in long term maintenance of treatment effects, a low cost variation of the intervention program is installed on a permanent basis, e.g., until the end of the current school year at a minimum. In this procedure, the playground supervisor(s) rates the child's overall behavior in each recess as either + or - on a daily basis. The child's teacher also rates his/her classroom behavior as either + or - twice each day—once in the morning and once in the afternoon. Each + counts toward a happy face on a wall poster. When completed, the poster is exchanged for a bonus reward—approximately once every 2-3 weeks.

Socially negative/aggressive children are extremely difficult for school personnel to manage effectively. A characteristic behavioral profile of such children includes: (1) argues and must have the last word in verbal exchanges, (2) intimidates other children, (3) uses coercive tactics to get his/her own way, (4) uses verbal derogation and ridiculing in social exchanges with other children, (5) is physically and/or verbally aggressive with other children. These children are frequently reinforced for behaving in this way via the natural consequences that are produced e.g., submission of others, getting one's own way and so forth. An extremely powerful intervention program is required to change this pattern of behavior and to teach a more positive cooperative style of interacting with others.

The great majority of socially negative/aggressive children are male. Of 31 children worked with to date, two have been female and the rest male.

In its final, completed form, each program is packaged in a self-contained fashion for use by school personnel under normal school conditions. Procedural manuals are prepared for each of the major implementation agents in the programs. These include: (1) the teacher consultant, (2) the classroom teacher and/or (3) the playground supervisor. Program tasks are described in detail and careful instructions are provided on how to carry them out. Videotaped presentations of actual and role played situations are developed for use in training teacher consultants in how to correctly implement key program components. To date, these tapes have only been used in workshop training sessions conducted by CORBEH. However, it is likely that videotapes of this nature will be included in a final commercially published version of the programs. If not, they should at least be available to consumers who wish to use them. Brochures and a cassette tape/film strip program overview, of 20-30 minutes in length, will also accompany each of the packages. These materials have proven very effective in disseminating information about these packages to potential consumers.

The CORBEH Research and Development Process Leading to Production of Packages

Approximately 4 to 5 years of research and development activities are invested in the development, testing and validation of each of the four behavior management packages. A three stage research model is used for this purpose. In research program I, the focus is upon development of an economical yet effective, set of procedures for changing the behavior of children representative of a given behavior disorder, e.g., acting out, social withdrawal and so forth. Emphasis is placed upon a precise, careful analysis of the functional relationships between different treatment variables and behavioral outcomes. The research in program I takes place within an experimental classroom setting where it is possible to establish tight experimental control over variables that have an impact upon child behavior. Small groups of subjects (usually 6 each), representative of a given behavior disorder, are assigned to the experimental classroom for a 3 to 4 month period and then returned to their regular classrooms. Once a set of treatment variables are identified that are effective for remediating a given behavior disorder within the experimental classroom, the development process shifts to research program II.

The focus of research in this program is upon adapting the identified procedures for effective use within regular classroom settings. Target children representative of the behavior disorder in question are selected using a combination of observation data and teacher and/or playground supervisor ratings. Program consultants employed by CORBEH then work with school personnel in delivering the treatment procedures in such a way that the target child's behavior is effectively changed within the regular classroom or playground setting. The goal of R & D activities at this stage is to produce an intervention package that will be practical, cost effective and viable for use by regular school personnel. The emphasis is upon producing replicable effects on the behavior of target children across different classroom/playground settings and teachers and supervisors. Once this goal has been achieved, the procedures are packaged for field testing in research program III.

The primary research questions in program III is whether teacher consultants employed by school districts can be trained to a sufficient skill level within a short term workshop (2 to 3 days) to apply the package(s) effectively and correctly. Field testing affords an opportunity to test the external generalizability of the package procedures through the use of experimental/control group designs. In field testing the packages' effectiveness is compared against whatever ongoing treatment procedures that control children are exposed to. By the time a package reaches the field testing stage, there is no longer a question of whether the procedures are effective in changing child behavior. Instead, the issues of concern relate to the packages' overall cost effectiveness, their practicality and the extent to which school personnel can be trained to implement them correctly.

Each of the four packages goes through this development cycle or process. After completion, the only additional work carried out on the packages relates to dissemination and in service training activities associated with the implementation process.

Administrative, Logistical and Fiscal Issues

There are a number of issues of this nature, associated with implementation of the packages, that can have an impact on their overall effectiveness. These can be classified into three general areas. These are (1) Administrative, (2) Logistical and (3) Fiscal.

ADMINISTRATIVE ISSUES

Perhaps one of the most important issues in this area is program support and a general willingness to cooperate with it. It is absolutely essential that the individuals most directly concerned with the program's implementation are supportive of it. These are usually (a) the teacher consultant, (b) the classroom teacher and/or playground supervisor and (c) the target child. If the target child has strenuous objections to participating in the program, an attempt should be made to identify the cause(s) of the objections and to resolve them if possible. If they cannot be resolved, some other program should be considered. It should be noted that such a development has never occurred in connection with any of CORBEH's programs. Perhaps this is because the available school and home rewards contained in the programs are so attractive to most primary level children.

Objections by the consultant, teacher and/or playground supervisor are a far more serious matter. No school professional should be pressured or coerced into participating in the program if they are not receptive to such involvement. None of the behavior management packages developed by CORBEH are sabotage proof. Unfortunately, it appears that the chances for a program's effective implementation are significantly reduced when a consultant, teacher or playground supervisor has hostile feelings about either the program or his involvement in it. In such cases, it is better not to implement the program at all and to consider some other, more palatable alternative for remediating the referral problem in question.

School personnel develop hostile feelings about programs such as those developed by CORBEH, for a variety of reasons. For example, some individuals are strongly opposed to the use of rewards of any kind for the purpose of motiving children to either learn or to change their pattern of behavior. Very often, the strength of such objections is more powerful than whatever potential benefits are perceived as accruing from application of the program to the child's problem(s). When this occurs, it is better to work out other alternatives for responding to the child's needs.

The CORBEH packages are as complex as they have to be in order to produce reliable and significant changes in child behavior within the classroom and/or playground setting. In their development, an attempt was made to reduce, to an absolute minimum, the amount of time requested of school personnel in their implementation. Nevertheless, some school personnel feel that the amount of work, time and energy required in the implementation process is simply too much and, in some cases, not justified by the potential benefits to be derived from the program's application. This is unfortunate since the end result is probably denial of the child's access to a program that could have a significant impact in remediating his/her behavior problem(s).

As noted earlier, teacher consultants invest approximately 35-45 hours of total time, from start to finish, in application of the program(s) to a single child's behavior or to a total classroom, as in the PASS program. The classroom teacher's and playground supervisor's roles in the programs are incorporated into their normal duties and routines. When one considers the potential therapeutic benefits to be obtained from the packages' application, this appears to be a rather modest investment of time, energy and effort. This is especially true if one considers the relative cost effectiveness of this intervention alternative against the usual educational alternatives used to remediate child behavior disorders in the school setting, e.g., special classes, resource rooms, counselling, psychotherapy and referral to outside agencies. In this context, the CORBEH behavior management packages appear to be well worth the investment of effort required of school personnel in their application. In addition, they have the added advantage of remediating child behavior disorders within the mainstream settings where they are problematic and of concern to school personnel. They do not require that the child be removed from such settings in order to gain access to treatment services. Many educators would see this as a significant advantage, especially given existing pressures for the mainstreaming of handicapped children whenever possible.

School personnel sometimes object to programs of the type developed by CORBEH for reasons other than those described above. For example, a common criticism of behaviorally based programs is that they deal only with symptoms and not with the more fundamental underlying causes of the behavior disorder. The focus of CORBEH's intervention packages is upon remediating the behavior problem(s) that are displayed in the school setting and that are of concern to school personnel. Identifying the original causes and etiology of different behavior disorders can be an exceedingly complex, difficult and often impossible task. Sometimes, literally years of psychotherapy are required to get individuals to conceptualize and to understand why they behave as they do. Even if they understand the basis of their behavior pattern or disorders, there is no guarantee, or even a good probability, that such individuals will change their behavior as a result of such understanding(s). It is the author's position that most school systems cannot afford the low level of cost effectiveness that such approaches to changing child behavior represent.

However, it should be noted that children experiencing behavior problems and/or disorders should be encouraged to understand the bases of their problematic behavior whenever possible. This can be accomplished via counselling techniques, feedback sessions, direct instructional techniques and so forth. There is no reason why such instruction cannot be implemented in conjunction with the CORBEH packages. Instruction of this type could increase their overall effectiveness and possibly contribute to greater generalization/maintenance effect(s). However, it should be noted that this is an empirical question which has not as yet been answered in relation to the CORBEH packages.

Perhaps the most constructive response to such substantive and philosophical objections is to provide accurate information about the program(s) in question, to document carefully each person's role in the program and what the potential benefits are. For example, for teachers who object to the amount of work involved, it should be pointed out that it is entirely possible that less time will be required in managing the target child's behavior after the program is over than is currently being invested. Further, the amount of time given is more likely to be positive in tone than negative e.g., reprimands, warnings, etc. The child's behavior pattern should be different as well. The cassette tape/filmstrip overviews and the brochures accompanying each package can be used for providing information about the packages in a fairly painless manner.

The support of the target child's parents, other teachers and the principal can also have an impact upon the program's effectiveness. Occasionally parents will object to their child participating in any special program. If their objections cannot be resolved, then it may be best not to consider the CORBEH programs (or any other special programs for that matter) unless the referred child's behavior is so disruptive that the school feels it absolutely cannot educate him/her using conventional methods.

Some parents have no objection to their child participating in the program, but do not want to be involved in the home part of it, e.g., praising her/his school performance, and arranging and delivering rewards at home. Still other parents agree to the child's participation and their role in the program and then do not carry through with their responsibilities. This can have a potentially serious effect upon the overall effectiveness of the program in remediating behavior disorders.

If parents agree to their child's participation but not their own, then a decision has to be made as to whether it is worth it to go ahead with the program. In such cases, the author recommends that the program be applied using only the school procedures. It seems unreasonable to deny a child access to a potentially therapeutic school service because her/his parents do not respond to a home involvement contingency, especially given the power of the school procedures contained in the CORBEH packages. In most cases, application of the school portion of the programs would, by themselves, produce significant changes in child behavior.

In the school portion of CORBEH's programs, the contingencies and rewards are of a group nature, e.g., the target child earns an activity reward of a group nature that is shared equally with classmates. Home rewards are designed to provide an additional source of motivation for the target child of a private, individual nature. If parents are unwilling to make such rewards available at home, and have no objection(s), individual reward(s) can be arranged for the target child at school instead of at home. This procedure has been used occasionally in the process of developing the packages and has worked quite well.

It makes an additional source of motivation available to the child that may be instrumental in affecting his/her response to the program procedures. The author has found that some children respond primarily to the home rewards of a dual school and home reinforcement system, others primarily to the school rewards and some to both equally. Having both motivational sources available increases the potential effectiveness of any school based program.

It's extremely important to obtain the active cooperation and program support of other school personnel such as other teachers and playground supervisors the child may be exposed to during the school day. If significant changes are to be made in a target child's overall behavior pattern, it is important that social agents at school respond to the target child's behavior in a consistent and similar fashion. Otherwise the child will quickly discriminate that different school personnel have differing behavioral standards and/or expectations and he/she will behave accordingly. In such cases, the intervention program is often blamed for variability or lack of consistency in the child's behavior when in fact inconsistency in the response of school personnel to the child's behavior is the actual cause.

It is the teacher consultant's responsibility to see that the program is effectively extended to other classroom periods and/or playground settings where the target child is experiencing difficulty. Sometimes, this is much easier said than done. For example, some school personnel may not feel the child's behavior is a problem in their classroom or setting. In these cases, it makes little sense to consider extending the program unless other information strongly suggests the child is experiencing difficulty and the social agent involved, for whatever reasons, does not wish to confront the issue.

It is more likely to encounter situations where other school personnel either (a) are opposed to the program on principle, (b) see it as too much work and as not justifying the time and effort involved and/or (c) agreeing to the program extension but not carrying through with their program responsibilities effectively. There are no easy solutions or answers to these problems. A number of procedures have been built into the CORBEH programs to respond to them. They have produced varying degrees of success.

These procedures have included the following, (1) involving all concerned school personnel from the moment of referral in reviewing the child's behavior problems and in planning the implementation process, (2) specifying in considerable detail each person's role in the program and the demands (tasks, time, effort) to be placed upon them, (3) describing specific therapeutic benefits to be derived from the program's application, (4) stressing the importance of consistency in program application across school personnel, (5) planning program extensions very carefully, monitoring the application of specific procedures, and providing the necessary supervision and resource support. These techniques, as a rule, are reasonably effective in facilitating successful program extensions. However, situations do occur in this context where success is not achieved in spite of the best efforts of the consultant. This frequently happens when the school personnel involved have philosophical objections to the program but agree to participate because of pressure from others, out of a sense of obligation or for other reasons. In such situations, the consultant must usually rely upon persuasion and continue to stress the therapeutic benefits to be derived if the program is applied correctly.

The school principal can have a powerful effect upon any program's impact. The CORBEH programs are no exception to this rule. The principal can be a powerful advocate of the program and its therapeutic benefits. It is important therefore to involve the principal from the start and to attempt to gain his/her active support.

It should be noted that active support of the principal can be a mixed blessing at times. There have been cases where a principal has been enthusiastic about a CORBEH program and the teacher involved has not been. As a result, the teacher(s) felt coerced into cooperating with the program without really wanting to. Almost invariably, such situations do not work out well for either the child, the teacher or the consultant. A teacher's objections should be largely resolved before he/she is asked to participate in the program. In a larger sense, it is unfair to everyone involved to do otherwise. CORBEH consultants, who serve as powerful child advocates in program applications, have had some unpleasant and very unrewarding experiences in trying to elicit cooperation from teachers and playground supervisors who were unsupportive and/or philosophically opposed to the program.

If the principal is actively opposed, for whatever reasons, to implementation of the program then it should not be considered further unless his/her substantive objections can be resolved. Principals sometimes object on philosophical grounds or on the basis of the program(s) representing an unnecessary burden for school personnel.

Sometimes a principal, while not an advocate of the program, will tolerate its implementation—adopting a sort of a wait and see posture. If other school personnel are reasonably supportive in such situations, it is desirable to go ahead with the program. If not, some other program or procedure should be considered.

Each of the CORBEH program manuals contains a section on common problems encountered in the implementation process. Probable causes are offered for such problems and prescriptions are provided for dealing with them that CORBEH consultants have found useful and/or successful. It is recommended that consultants review these sections of the program prior to implementation.

LOGISTICAL ISSUES

Logistical issues, as used in this context, refers to the management of an implementation procedure designed to remediate child behavior disorders in the classroom setting. The precision with which any intervention procedure is managed bears a direct relationship to its effectiveness. In this respect, one must not only have the necessary technical skills to implement procedure(s) correctly but also be willing to invest the monitoring and supervision time required during the program's implementation.

Three primary components are involved in the delivery of treatment services to target children via CORBEH's behavior management packages. These are (a) the preparation of procedural manuals describing implementation tasks and details for teacher consultants, classroom teachers and playground supervisors, (b) training teacher consultants to mastery, both conceptual and behavioral, on key components of the implementation process, (c) defining, in explicit detail, the consultant's role in the daily operation of the program, especially with respect to program monitoring, supervision and resource support of teachers and playground supervisors. These three components, more than any other variables, determine the effectiveness of the program in producing desired behavioral outcomes.

The program manual for teacher consultants contains a complete description of the intervention procedures along with instructions on how to correctly implement them. Each consultant manual is divided into three sections. These are: (a) *pre-intervention procedures* which describe all the tasks that have to be completed in order to make the program operational, (b) *intervention procedures* which describes how to implement specific behavior change procedures and (c) *common problems* which detail problems encountered in the implementation process and solutions that have been used to resolve them.

Less complex procedural manuals are prepared respectively for classroom teachers and playground supervisors. These manuals teach essential skills, such as scanning and praising, and describe daily tasks that must be achieved in order for the program to operate effectively. They serve as a valuable reference manual for the primary delivery agents in the program and are indispensable to its successful implementation.

As noted earlier, the teacher consultant bears overall responsibility for implementing the program and for insuring its correct application so as to produce the desired results. The consultant also operates the program initially and then trains the teacher and/or playground supervisor to assume control of it. Once this transition has been achieved, the consultant assumes a resource, supportive role for the remainder of the program. Given these responsibilities, it is absolutely essential that teacher consultants be trained to a minimum level of mastery in the program and its implementation.

To date, CORBEH has used a 3 day intensive training workshop, conducted in local school district sites, for the purpose of training teacher consultants in its behavior management packages. The CLASS and PASS programs have been field tested in nine school district sites over the past four years. In each site, groups of 15 to 25 teacher consultants employed by the local school district, have been trained to mastery levels within a 3 day intensive workshop. Training activities are conducted by CORBEH program consultants and usually involve the following sequence: (1) reading and reviewing the consultant's program manual, (2) demonstrating conceptual mastery of the material via paper and pencil tests, (3) review and discussion of critical components of the program, (4) role playing and/or actual behavioral rehearsal of key components, (5) receiving performance feedback in post roleplaying/rehearsal sessions and (6) question/answer sessions. Extensive use is made of videotaped illustrations of key program components in training. The focus of such illustrations is upon demonstration of each component's correct implementation. This training model has been used in all nine field test sites and has proven highly effective.

An additional twenty, onsite training workshops in CLASS and PASS have been conducted as part of CORBEH's dissemination effort. In these activities, workshops have been reduced from three to two days in length. According to feedback from participants they are able to implement the programs effectively with this reduced training.

A question of current interest in relation to CORBEH programs is the minimum amount of training that is required for consultants to implement them effectively, as determined by positive changes in child behavior. The author received a grant from the Bureau of the Handicapped in 1974 to research this question.

The CLASS program was used as a vehicle for investigating this question. A total of fifteen teacher consultants were identified in each of these field test sites. The consultants within each site were randomly assigned to one of the three training groups. The training groups were as follows: *Training Group One* received no external training in the CLASS program from CORBEH trainers. Participants in this training group were instructed to train themselves in the CLASS program materials. All training materials used by CORBEH trainers, e.g., videotapes, transparencies, handouts, etc. were made available to members of this group. *Training Group Two* received a two day workshop session, conducted by CORBEH trainers, in which they were systematically exposed to all program components. However, they were not trained to mastery criterion on any of these components. *Training Group Three* participants received an intensive three day training workshop in which they were thoroughly trained on all program components judged to be critical to the program's successful application. Extensive role playing and behavioral rehersal procedures, with performance feedback, were used to train group three participants in program components. All three training groups demonstrated *conceptual* mastery of the material contained in the teacher consultant manual via a 112 item objective test before any training in *behavioral* mastery of program components was initiated. Consequently, the question addressed in this particular study was the minimum amount of external training in *behavioral* mastery of the CLASS program procedures necessary for effective application as determined by appropriate changes in child behavior.

Each trainee identified one primary level acting out child enrolled in a regular classroom setting and applied the class program to his/her behavior over a 2-4 month period. Participants in all three training groups produced very powerful changes in child behavior as a result of the CLASS program application. Further there were no differences in the effectiveness with which the three groups applied the procedures as determined by changes in the behavior of the target acting out children involved. The study results indicate that if a teacher consultant is sufficiently motivated, conscientious and attentive to detail, it is possible to master the CLASS program procedures without external training, and apply them effectively. This is an important finding as the CLASS program approaches the dissemination stage. It means that school professionals are not necessarily dependent upon CORBEH training personnel for mastery of program procedures. Similar studies have not been carried out with PASS or with the other packages under development. However, because of similarities to CLASS in their content, formating and packaging, there is a high probability that similar results would be obtained.

The study's results also suggest that the CLASS program is sufficiently well programmed to be largely self-instructional, given access to CORBEH's training materials. To facilitate the self training process, CORBEH has prepared a CLASS consultant trainer's manual which describes the training procedures and materials that CORBEH has used in field testing and dissemination activities and which have proven effective in building in mastery of critical program components. Any consultant, or group of consultants, should read this manual carefully as part of a self training effort.

In the context of logistics vis a vis implementation of CLASS, there are three final issues or variables that potential consultants should consider carefully. These are (a) consultant motivation and available time to implement the behavior management packages, (b) maintaining the implementation efforts of classroom teachers and playground supervisors and, (c) giving negative feedback and criticism(s) when necessary.

Unless teacher consultants are philosophically opposed to a program such as CLASS, it is unusual for them to be uninterested in it or unmotivated to apply it since its potential for producing positive changes in child behavior is so apparent. However, a number of potential consultants have given feedback to the effect that school demands upon their time are so intense that they have difficulty making a commitment to implementing a program such as CLASS. Given the relatively modest time demands placed upon consultants in applying CLASS, this is an unfortunate occurrence when one considers the potential gains to be realized. Nevertheless, the author is convinced of the validity of consultant's claims regarding school pressures. If a consultant feels she/he truly does not have the time available to implement CLASS, then it is probably unwise to do so. The program should not be perceived as a burden. If this occurs, then its implementation can be frustrating for everyone concerned.

If a potential consultant does have the time available to implement the program, a good rule to follow is that no more than two children should be receiving the CLASS program at any one time. Given the consultant's other responsibilities, operating the program on more than two acting out children at once would represent an insurmountable burden. However, it should be noted that consultants become both more skilled *and* efficient as they gain experience in implementing CLASS.

Maintaining the implementation efforts and behavior of teachers and playground supervisors is an extremely crucial consultant responsibility within CORBEH's behavior management packages. Teachers and playground supervisors are the primary agents for delivery of treatment services to target children in CORBEH's programs. Further, they must continue to interact with and manage the behavior of target children after their direct involvement, and that of the consultant, in the program is over. The effectiveness with which such school personnel implement the program is probably directly related to the quality of their behavior management efforts following program termination. Teacher consultants can have a powerful impact upon the effectiveness of program implementation through their interactions with teachers and playground supervisors.

It goes without saying that teacher consultants should be sensitive to the feelings, attitudes and behavior of teachers and supervisors during the implementation process. School personnel are often defensive about their inability to control a given child's behavior and will be most uncomfortable with any suggestions or indications that they are responsible for the target child's behavior problem(s). Consultants should be extremely careful not to communicate this attitude even though it may be true. It is far better to concentrate on efforts to remediate such problems than to identify and attempt to fix blame for causative factors.

Teachers and playground supervisors may have different strengths and differing entry levels with respect to skills required in implementing the program. Consultants should be sensitive to such differences and be prepared to provide more training, monitoring and support in deficient areas. Areas of deficiency can be identified through interviews, through role playing and behavioral rehearsal sessions and by observing teachers and playground supervisors carefully as they implement the program.

It is absolutely essential that consultants provide regular feedback to teachers and playground supervisors on the quality, precision and correctness of their implementation efforts. This should be done after each daily session initially, then daily and finally less frequently as the program progresses and as skills develop. The consultant's manual contains recommended schedules of monitoring and supervision. However, these represent the *minimal* amounts of time that are considered essential for successful implementation. Individuals will vary considerably in the amounts of monitoring, supervision and continuing training they will require. The consultant will have to exercise considerable judgement in this area.

As with the target child, consultants and playground supervisors must be motivated to continue a high quality effort during program implementation. Usually child behavior changes radically, in the desired direction, in the early stages of program implementation. Presumably this would be a powerful reinforcer for school personnel and it probably is for most. However, it is often not sufficient to maintain their behavior by itself, especially when difficulties in implementation are encountered. Teachers and playground supervisors usually need a great deal of encouragement and specific praise for their implementation efforts. Consultants should be highly sensitive to this issue and praise teachers/supervisors at a high frequency. In the early stages of their involvement in the implementation process, teachers and supervisors should be praised for something they did well at least once per day. Encouragement can be given at any time it seems appropriate and is needed. Consultant praise, if given in a genuine/meaningful manner, can have a powerful impact upon how well teachers and supervisors implement the program.

In contrast, there are times when negative feedback and/or criticism must be given by the consultant. If specific program components are being implemented incorrectly or ineffectively, immediate steps must be taken to change the situation. This often involves the use of criticism and negative feedback.

However, there is criticism and then there is criticism. Negative feedback and criticism can be effective change procedures if delivered in the right way. All feedback of this nature should be therapeutically based, not personal and focused upon improving the implementation process. Before delivering such feedback, it is helpful to review positive features of the teacher or playground supervisor's past performance and then to introduce the area(s) in which problems and difficulties are being encountered, e.g., "You are doing well in these areas (specify) but there are some problems in these other areas (also specify).

Be prepared to accept some defensiveness as a natural and frequent, reaction to such feedback. Be as nonreactive to such defensiveness as is possible and appropriate while still giving the teacher/supervisor an opportunity to express his/her point of view on the matter(s) involved. It is helpful to present this information in a manner so that it is clear you are simply trying to improve the implementation process, and subsequently program effectiveness, and that you are not attacking the individual's competence. This is not an easy task and requires a great deal of skill and sensitivity on the consultant's part. It may be helpful to role play such feedback sessions in advance with a colleague to improve delivery skills and to gauge how the information might be received. This also provides an opportunity to consider potential responses depending upon how the teacher/supervisor reacts to the information. Under no circumstances should such feedback be delayed or avoided because of an anticipated negative reaction.

FISCAL ISSUES

To the author's knowledge, there have not been direct cost effective comparisons of programs for remediating classroom behavior disorders of the type developed by CORBEH against placement in special or resource classroom settings. However, given the costs of maintaining special/resource classrooms, the problems that exist in getting treatment effects produced in such settings to generalize to other settings, e.g., the regular classroom, and the relative effectiveness of CORBEH's behavior management packages in remediating behavior problems in mainstream settings, it is probable the packages would prove to be highly cost effective in such comparisons.

As to costs of implementation it is difficult to estimate them precisely given differing salary structures, administrative arrangements and staffing patterns across school districts. The major variable to consider in this respect would be the availability of teacher consultants and the costs of their time involved in program implementation.

Once the packages are commercially published, they will no doubt be more expensive than at present. Currently the costs of program manuals for each package are $3 each. There are 3 to 4 manuals per package depending upon whether it is a classroom only or classroom and recess program. A cassette tape/filmstrip overview of each package costs approximately $25-30. There are approximately 4-8 hours of videotapes available for each package which illustrate the correct application of various program components. At present, their costs would be limited to the cost of videotape, reproduction and mailing. Further, the package(s) can be used repeatedly with essentially no additional costs beyond those described above. Thus in terms of materials, the costs go down with each additional application.

Some districts have used the CLASS program in ways that help determine the level and cost of service a given behavior problem child will require in order for his/her behavior problems to be remediated effectively. For example, in some districts, when a child is referred for possible assignment to a special or resource classroom because of disruptive behavior problems occurring in the regular classroom, the CLASS program is implemented in the regular classroom first. If it is effective in changing the child's behavior, assignment outside the regular classroom is not considered further. If it is not effective, procedures are initiated for assignment to such a setting which represents a more intensive and costly treatment service. When referred children qualify, this appears to be a highly appropriate use of the CLASS program as well as other CORBEH programs either completed (PASS) or still under development (PEERS, RECESS).

Conclusion

The intent of this paper has been to present information that would improve the effectiveness of application of CORBEH programs by school personnel. For school personnel considering implementing these programs, the material presented communicates what we have learned about variables that impact upon the packages' effectiveness in the school setting. In a sense, an attempt was made to give the reader the benefits of our experience in this area and to suggest effective responses to problems encountered in implementation. A school district considering the implementation of one or more of CORBEH's behavior management packages should review the material presented in this paper carefully.

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The Administration of an Agency That Recognizes It Cannot Be All Things to All Children and Their Families: An Ecological Approach

Don E. Hartstern

Introduction

In the late 1950's, Dr. Nicholas Hobbs, then at Peabody College for Teachers in Nashville, Tennessee, compiled existing research related to the availability of services to the emotionally disturbed child. These findings revealed an alarming gap between services available and identified children in need of mental health services. As a result, the National Institute of Mental Health (MH929) made it possible to design and implement a new kind of service to help the emotionally disturbed child. This new service was known as Project Re-Ed and got under way in 1961.

From the outset, Project Re-Ed was concerned with the problem of money and the obvious lack of traditional mental health manpower. These problems are still very much a concern in 1977, particularly with the demands being placed upon public education to provide "programs" for emotionally disturbed children. Therefore, this paper is to provide information and a philosophy that may help administrators by looking at another way they may deal with the demands for services to disturbed children.

The Ecological Bias

As an administrator of programs for emotionally disturbed or behaviorally disordered children, my experience with Re-Ed gave me the ecological bias and a model in which I could administer services and not feel I had to be all things to all disturbed children and their families who came into the agency. The ecological concept emphasizes the interactive quality of children's problems and the social context in which they occur. Problems are seen as property of an ecological unit to which the child belongs, including the primary agents of his socialization—family, public school, peer groups, etc. (Bower, 1969)

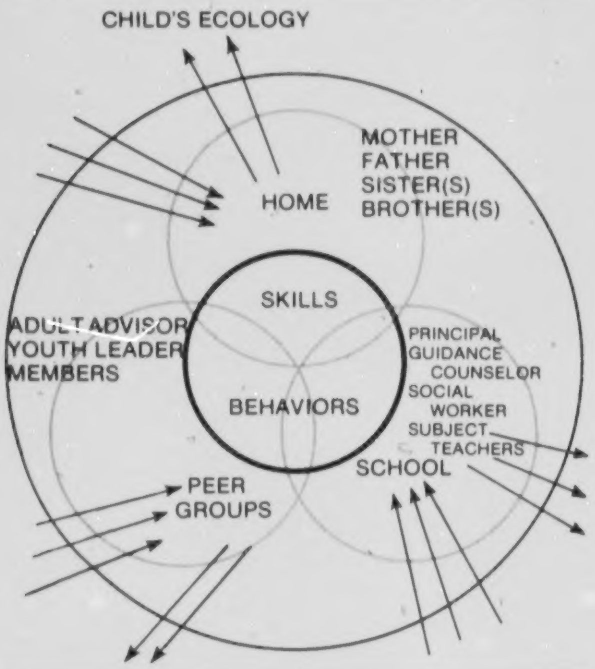
The Ecological Model

In assessing children as a product of their ecology, one starts with the assumption that the child is a repertoire of skills (defined as learned competencies, attitudes, and abilities) and behaviors (observable and measurable). (See Fig. 1) However, the assessment cannot be done in a vacuum, meaning without benefit of information which establishes relevance of the child's behavioral repertoire and where it is he/she is to behave; referred to as behavioral settings. The most common behavioral settings for children are the home, the school, and his peer groups. It should be noted that the identification of informal peer groups are important, but, for our purposes are difficult to analyze; therefore, one usually explores the formal peer groups in which there is organization and defined leadership. Once behavioral settings have been identified, the model requires the identification of significant people within the behavior setting. Significant others are defined as those persons who have responsibility for the child's behavior in that behavior setting.

At this point in assessing a child's ecology, it is difficult to separate the model from the person who is doing the assessment. This will be described in the following section, "The Liaison Person." For sake of explaining the model, however, Fig. 1 (shown below), represents the retrieving from the significant people in particular behavior settings, behaviors of the child which are appropriate or are in accord with the expectations of that person in that behavioral setting, as well as the retrieving of behaviors which are *not* in accord with expectations.

Thus what we have is a picture of a child's world which is peculiar only to that child. This is that child's ecology, constituting the ecological model.

FIGURE 1. The Ecological Model



The Liaison Person

As stated in the introduction of this paper, Project Re-Ed was concerned with the problem of money and manpower. Therefore, creating a new professional was not part of the original plan. However, time and experience with the ecological model brought to be a new role for personnel in the Re-Ed centers who were responsible for the retrieving and disseminating of ecological information about a child. It became apparent that there was a need for a new role—the liaison person. This role was not intended to create a new professional discipline but a matter of redefining priorities for existing trained personnel such as social workers, guidance counselors, etc.

In looking at the process of assessing a child's ecology, it became apparent that the liaison person could be more effective in the treatment or the therapeutic process by defining their role in such a way as to reflect the ecological process from referral through termination and followup:

1. identify behavior settings and its significant people;
2. retrieve the behavioral information about a child in such a way as to establish a positive relationship with the significant people and help them translate their feelings into behaviors;
3. interpret *all* information and reports about the child in such a way as to make it relevant to actual or available treatment resources;
4. based upon the assessment, acquire existing services for, or in behalf of, the child and his family;
5. communicate progress of treatment to the child's ecology; monitor and reassess effectiveness of treatment and therapeutic resources that are also acting upon the child's ecology; and,
6. link behavior settings and community resources in such a way that they can function in behalf of the child, then monitor during the followup period.

In administering programs that utilize this model, I found it important to solicit from the staff person that will occupy this role several commitments:

1. a commitment to the model;
2. a commitment to collecting information and data before treatment or recognizing that intervention prior to the collection of the data is temporary and subject to change;
3. a commitment to abandon their personal need to be a "therapist" in favor of being "therapeutic," i.e., they will find treatment resources without doing it themselves;
4. a commitment to continually update the ecological information and find new and/or different resources that can be effective in the child's ecology; and,
5. a commitment to monitor services and evaluate effectiveness as it relates to treatment goals.

Since Peabody College was instrumental in developing Re-Ed, it is natural that they be instrumental in developing a liaison training program. For information about the training program, I refer you to the *Journal of Community Psychology*, January, 1977. In this journal there is a description of the training program, as well as articles describing the liaison role and functions.

Least Restrictive Alternative of Care

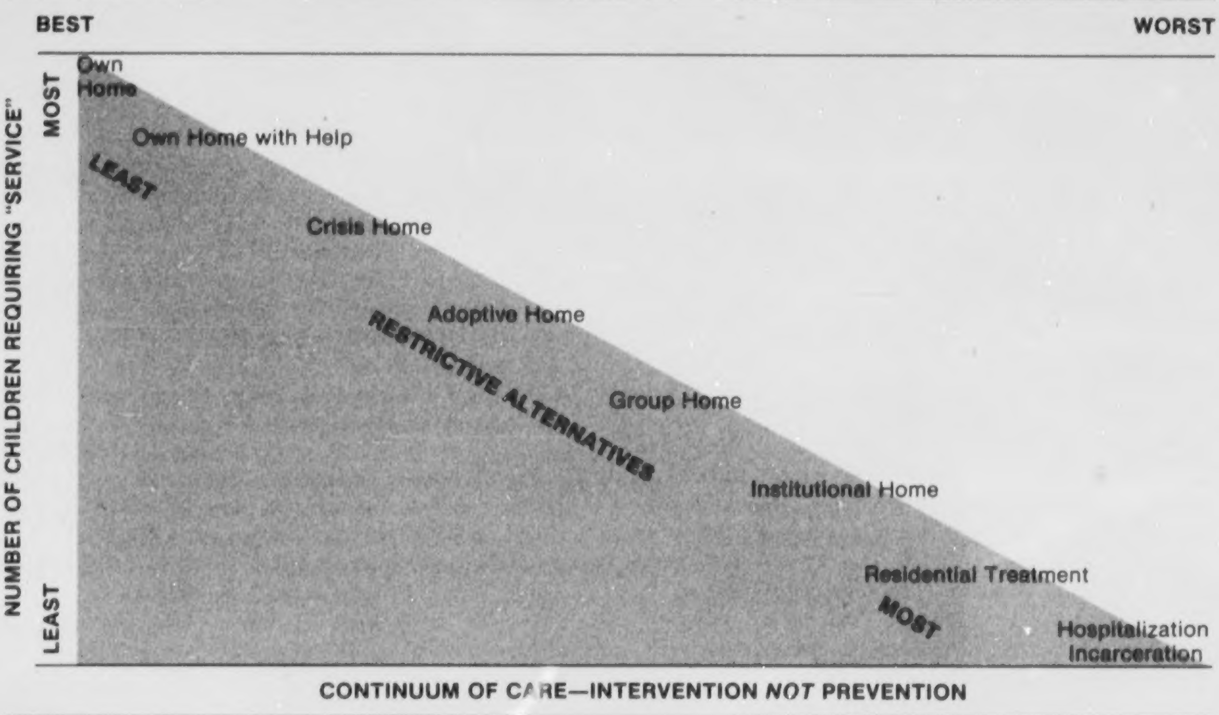
Another concept that is helpful for me in administering programs for disturbed children is the "intensity of care" or "least restrictive alternative of care" which is very popular today.

In this concept, what we are concerned about is the personal adjustment of a child as it relates to treatment. We shall start with the assumption that most children adjust very well in their own home and in the "mainstream" of their normal ecological resources. When this does not hold true, then we must proceed to look for "special" services for children and their families but maintain the child in his own home. When the home situation is deteriorating and requires removal, then we must consider the prognosis of this home being stable enough to accommodate the child. If the assessment of the home situation reveals an unexpected emergency or crisis that can be resolved in a short period of time, then removal to a crisis home would be appropriate. If the prognosis is that this home cannot accommodate this child, particularly during his formative years, then I would pursue adoptive home placement. I avoid the concept of foster home for it is plagued with uncertainty and temporariness for the child as well as the foster family. Perhaps it is a matter of terminology, but I feel the assessing of what is best for the child and his family must be clearly defined prior to implementation of alternatives.

Group homes, institutional homes, residential treatment centers, and hospitalization or incarceration are all forms of treatment facilities. Selection of the least restrictive is contingent upon the severity of the child's problem.

What I wish to emphasize with this model is an awareness that professionals must assume responsibility when making "intensity of care" decisions. It is often very convenient to select a more restrictive alternative before eliminating the lesser restrictive forms of care. (see figure 2 below)

FIGURE 2. Progress of Personal Adjustment



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Division TEACCH: Toward a Statewide Network of Public School Services for the Autistic Child and His Family

Lee M. Marcus, Ph.D.,
Louis P. Semrau, Ph.D.,
and Eric Schopler, Ph.D.

Overview

This paper describes Division TEACCH, a statewide program for the *T*reatment and *E*ducation of *A*utistic, psychotic and related *C*ommunications handicapped *CH*ildren. The program is organized to provide a comprehensive range of services individualized according to the needs of each child and his family. Mandated by the North Carolina state legislature, since 1972 it has been a separate Division within the Department of Psychiatry of the School of Medicine at the University of North Carolina, Chapel Hill, North Carolina.

The main text is divided into four major sections. The first part describes the population served by the program, specifying characteristics and features that distinguish this group from other handicapped groups. The second section details the organizational structure of Division TEACCH. The third section reviews the intervention model, including the historical background, clinical and classroom approaches, and procedures and the role of parent involvement. The last major section discusses how the model is implemented, including the program's process orientation, its staff selection, training and support methods, and its relationship with local school systems and other agencies. The research component is then described; concluding comments follow this section.

Appendices are included to provide a selected bibliography, sample diagnostic, home teaching program, and classroom progress reports, a summer training program, copies of the state legislation and standard contractural agreement between TEACCH and local education agencies (LEAs), a sample annual classroom report, and a recent summary report of total services prepared for the legislature. This latter report includes general statistical information on the population served by the program.

Description of Population

In every community there are youngsters who do not seem to "fit" programs established for the mentally retarded, the learning disabled, the emotionally disturbed, orthopedically handicapped, brain-injured or multiply-handicapped. These children are often designated as suffering from autism, childhood psychosis, or some other form of related communications handicap. Researchers and clinicians have not been in agreement about the exact definition of autism. Children with similar problems and handicaps are frequently identified with different labels. These include psychotic, schizophrenic, symbiotic, atypical, borderline psychotic, autistic, autistic-like, and so on, to name only some of the best known ones. The label applied often depends on what part of the country the diagnosis is made and on the theoretical persuasion of the diagnostician. The main reasons for the diagnostic confusion is that these children suffer from a heterogeneous group of disorders, for which the specific underlying causes are not clearly demonstrable.

Nevertheless some clarification of the diagnostic confusion has emerged over the years and is summarized in Rutter and Schopler (in press). Although most educational and therapeutic Programs still differ in the specific definition of their autistic population, there is now a general consensus about four broad features of the condition. These include:

1. A severe impairment in communication such that speech may have been lost, delayed or never acquired, or if acquired, speech is characterized by peculiar and bizarre usage, including jargon, echolalia, pronoun reversal and other deviations.
2. A major impairment in human relatedness, manifested by marked aloofness or extreme negativism When interpersonal contact is initiated or responded to, it often has an empty, impersonal quality.
3. Unusual use of the body with stereotyped and repetitive mannerisms such as rhythmic rocking,

spinning, finger flicking, self-directed aggression, and other perseverative behavior patterns.

4. Early onset or manifestation of the disorder, before three years of age.

Other behavioral characteristics are included in the definition, but these tend to vary more in their emphasis from one program to another. At Division TEACCH a rating scale is used with 15 different items (Reichler & Schopler, 1971), based on the nine criteria of Creak (1964). Also included are children with a wide range of communication problems, usually combined with behavior difficulties, not typically classified under the definition of autism or psychosis. This is done because the special education needs of these children are quite similar to those of the autistic child.

It is important to recognize that differences in specific 'escriptions of their population by various centers and programs may be due to valid differences between program mandates and purposes. Thus, if a program has a special interest in language research and treatment, the population of autistic children may be restricted to those functioning at a near normal level in all but language areas. If a child is to be placed in a classroom, his activity level and the number of hyperactive children already in the class become important diagnostic considerations. For the purpose of administrative placement decisions, the severity of the child's social or intellectual impairment becomes a critical issue. At TEACCH a commitment has been made to the broadest range of children with this disorder to help provide or locate the most appropriate education for them.

One further point needs emphasis: although autistic or psychotic children show disturbed behaviors, it has become increasingly apparent that the education and treatment often provided for the category of emotionally disturbed is not appropriate for the autistic child. First, their behavior problems most likely result from their cognitive and communication disorders rather than from emotional conflicts, inadequate social learning environment or sociological factors. Accordingly, special education classes that attempt to help these youngsters to work through their emotional blocks through free self expression or related therapeutic approaches are usually counterproductive for them (Schopler, Brehm, Kinsbourne & Reichler, 1971). Second, their fundamental learning handicaps require more specialized and different instructional methods than is appropriate for emotionally disturbed children. Third, for the majority of psychotic children, normalization, or the potential for return to a regular classroom setting with minimal support, is unlikely and thus provisions have to be made for continuity of services throughout the life span. Finally, although controversial and less immediately relevant to education, the origins or causes of autism or psychosis probably lie in biological processes rather than environmental circumstances, typically associated with emotional disturbance.

Division TEACCH: Organizational Structure

The TEACCH program provides a statewide network of services to families of autistic or psyhotic children in North Carolina. It is based on a clinical model of individualized instruction, counseling and training to children and parents. Currently there are four regional evaluation and treatment Centers located in Asheville, Chapel Hill, Charlotte and Greenville and eighteen special education classrooms located throughout the state and attached to the Centers. Research and Administration headquarters are based in Chapel Hill. Clinical and classroom programs are primarily funded by state monies allocated specifically to Division TEACCH; additional support comes from Title I and Title VIB ESEA grants and local school funding. TEACCH is a separate division within the Department of Psychiatry at the University of North Carolina School of Medicine, Chapel Hill. While its principle focus is service delivery, it also provides considerable training and dissemination experiences for students in education, psychology, allied medical professions, speech and hearing, social work, and related fields.

The administrative structure is relatively simple: each regional Center is supervised by a Clinical Director who has responsibility for the diagnostic and treatment services of the clinic and the day-to-day operation of the classrooms within the region. The clinic staffs are specially trained psychoeducational therapists who come from a diversity of backgrounds in the social sciences. There is no role hierarchy or differentiation among the staff, reflecting the philosophy of the program that no particular field or discipline (e.g., psychology, speech pathology) or orientation (e.g., psychoanalytic or behavior modification) is best suited to meet the total needs of the child and his family. The staff provides diagnostic evaluation, individual educational and management programs, parent training and counseling, consultation to the classrooms and other programs within the state and helps with training and dissemination. The older centers carry a staff of 4-5 psychoeducational therapists.

The classrooms are staffed by a teacher and an aide who work with a typical group size of 6-7 youngsters. Additional services to the classrooms come from the Centers. The classroom personnel are officially hired by the LEAs but selected by the LEA and TEACCH—thus, they are a part of two state systems. The relationship between TEACCH and the LEAs is discussed later.

The overall direction and supervision of the program comes from the Director of Division TEACCH; in addition the ultimate responsibility for the classroom programs is taken by the Director of Educational Training who assists and is responsible to the Director.

The Intervention Model

HISTORICAL BACKGROUND

The current TEACCH program is an expansion and further development of an earlier federally-funded research project, the Child Research Project (CRP), developed by Drs. Eric Schopler, Division TEACCH Director, and Robert Reichler in 1968. The philosophy, goals and methods of that project, based on a Developmental Therapy model (Schopler & Reichler, 1971a), have continued basically intact despite staff turnover and steady expansion.

The primary aim of the CRP was to demonstrate the feasibility of training parents to function as co-therapists with their own psychotic children. This aim was based on the assumptions that parents were highly motivated to teach and manage their children, that they had time available that professionals did not, that fundamentally they understood and cared for their child more than anyone, and that over the years they were obliged to be the child's best advocate. These assumptions were substantiated over the five-year period of the grant and the primary aim was accomplished. A viable clinical structure was developed including methods for training parents, assessing and developing home teaching programs for the children and generally bringing the parents directly into the treatment and educational process, an innovative concept. In recognition of the clinical and research work of the CRP, in 1972 the American Psychiatric Association presented its Gold Achievement Award; in addition, the program became the first one to be endorsed by the National Society for Autistic Children.

The collaboration of parent and professional, initiated at the clinical level, was transformed into coalition activity for development of appropriate educational and recreational services for autistic children. The formation of the North Carolina chapter of the National Society for Autistic Children led directly to the passing of legislation mandating the TEACCH program. (See Appendix B). It was the intent of this legislation to make available on an ongoing and statewide basis the experience demonstrated as effective under the CRP. Parents were directly involved in the teeching and management of their own children, on an individual basis at the Center. Parents were also involved in the education of their children in the classroom. This provided a unique opportunity to offer a relatively integrated learning environment between school and home through parental involvement.

The close working relationship between the state program and its constituency, the parent organization, remains the core asset of the service delivery system. Currently, parents throughout the state are actively supporting legislation for funding additional TEACCH services in the Wilmington and Charlotte areas. At the same time, TEACCH has provided intensive training and consultative support to a new adolescent group home project run by the parent organization. In the past, parents of autistic or psychotic children have been maligned and blamed for their children's problems; they were excluded from appropriate educational and therapeutic services. The dramatic shift in the availability of programs within the past decade in North Carolina reflects the value and significance of systematically including parents in the decision-making process.

ASSUMPTIONS OF THE CLINICAL APPROACH

Critical to an understanding of the best method of intervention with the psychotic child is the recognition that he is handicapped by severe deviances in developmental functioning, that the best treatment or teaching responses should relate to developmental needs across several areas and that it is helpful to understand commonalities between the psychotic child and younger more normal children. It is assumed that these developmental abnormalities can be adequately assessed and appropriate decisions for individualized instruction can be based on such an assessment.

Another assumption is that each youngster and family requires a set of priorities based on the most significant learning and management problems that are preventing the child from access to more normal social, educational and recreational experiences. Thus, the clinical approach endeavors to build basic competencies that will enable the child, his family and relevant social institutions to live together more effectively.

A final assumption is that the most effective response or strategy for clinical intervention should be pragmatic, flexible and realistic and not allied to a dogma or school of thought. Factors such as intellectual potential of the child, skills and emotional resources of the family, availability of local community services to provide back-up support are just a few of many factors that are considered in selecting short and long-range goals for the psychotic child and his family.

CLINICAL PROCEDURES

1. *Referrals:* Youngsters are referred from numerous sources including public schools, developmental evaluation clinics, mental health agencies, pediatricians, child psychiatrists, neurologists, or parents. Admissions criteria, which are somewhat flexible, require that the child is diagnosed with psychosis, autism or a related communications disorder; that he functions within the preschool or preadolescent age level; that parents are willing and able to participate in the program (exceptions are

sometimes made if a day program staff member can make a comparable commitment in lieu of the parent).

2. *Diagnostic evaluation:* The child and his parents admitted to the program are seen for a full day evaluation. The child is assessed on the Psychoeducational Profile (Schopler & Reichler, 1976), a specially designed instrument that comprehensively tests critical areas of developmental functioning and allows for careful clinical observation of learning and behavioral characteristics. The test minimizes dependence on language-related tasks, the weakest area of functioning for the psychotic child, and is flexibly administered to enable the examiner to make judgment about potentially useful teaching strategies. Age scores are derived and a profile is drawn to give a picture of relative strengths and weaknesses and a sense of the unevenness of developmental functioning. Individualized teaching programs are developed from an analysis of the child's areas of emerging ability; that is, those skills and tasks that have not been mastered but in which the child is beginning to show some competency.

Psychological testing is given later in the day to establish a rough estimate of the child's functioning (i.e., IQ) in relation to normal children of his age and to determine a baseline for future evaluations. It has been the experience of the program that given the appropriate psychological test, most, if not all, psychotic children can be adequately and reliably tested (Schopler & Reichler, 1971b). At TEACCH the Leiter International Performance Scale, Merrill-Palmer Scale of Mental Tests, and Bayley Infant Development Scales are better suited to these children than are the traditional Wechsler and Stanford-Binet instruments. Another important factor in deriving an IQ estimate is to help determine realistic, language expectations for the family based on the consistent research findings that IQs less than 50 tend to remain stable whereas IQs over 50 tend to be more unpredictable.

While the child's skills are being assessed, the parents are interviewed by another psychoeducational therapist who explores their concerns, priorities, hopes and expectations, background and relevant family factors. The Vineland Social Maturity Scale is administered to establish the level and pattern of skills in self-help, socialization and communication at home.

Following a staff conference in which the testing and home information is summarized and a plan is formulated, the parents, clinical director, and therapists meet for an Interpretive Conference during which parent concerns are addressed, information is frankly shared and a tentative contract is set up to work collaboratively. A contract is essentially a detailed agreement of responsibilities between the parents and TEACCH for goals and intervention procedures for working with the youngster.

3. *Treatment:* The extended diagnostic or initial treatment phase consists of six to eight one-hour weekly clinic sessions during which the parent works with a child therapist and parent consultant. Sessions with the child therapist utilize a one-way screen so that demonstrations by the therapist can be observed by the parents. The therapist develops a written program for the parent to carry out on a regular basis at home and which is subsequently demonstrated by the parent during clinic sessions. The home programs contain tasks, games and activities based on the assessment of the child's needs and emerging skills; by successfully learning how to teach their children, parents gain an increased understanding of their child's problems and a more effective relationship. The parent consultant serves in a sense as a parent advocate, making suggestions about management techniques and building self-help skills, arranging for neurological, dental or other medical services if necessary, helping with educational planning and eventual placement and above all being available to share the parents' burden and struggles in coping. This initial phase of treatment is active and intense and inevitably produces a positive shift in the family's ability to deal with and gain some control over their child's psychotic behaviors and learning readiness skills.

Following the six to eight week extended diagnostic, a conference is held with the family to set a new contract which might involve less frequent clinic visits over the period of the next year. Annual re-evaluations are done with families continuing in active treatment.

4. *The classroom program:* Families who have been through at least an initial diagnostic session (and in many instances the extended diagnostic phase) may have their youngster enrolled in one of the TEACCH classroom programs, if (a) that placement is considered the most appropriate service available and (b) the family lives within or nearby a community in which a classroom is located. By contractual arrangement with local school systems, youngsters must have been evaluated at a TEACCH regional center before considered for enrollment. This agreement enables a consistent selection and placement procedure to be maintained; in addition the Center's diagnostic findings and experience with the family are transmitted to the classroom staff to facilitate appropriate programming.

The classroom programs are essentially applications of the individualized clinical approach to a group setting. The basic services offered to families in the clinic —home programming, behavior management suggestions, help obtaining additional needed services—are adapted to the classroom with backup support from the regional centers. Of course, the added ingredient is a full day public school program with opportunities for more normalizing experiences such as eating in a cafeteria and participation in playground activities.

The teaching staff is provided basic training; then armed with the psychoeducational testing information, examples of earlier home programs and knowledge of specialized instructional and management techniques, they work with youngsters individually and in small and large groups. The teacher and aide work collaboratively and share responsibility for planning and executing teaching programs. Although the final decision-making authority and responsibility reside with the teacher, the success of a program requires a total commitment and effort by both staff members.

Individualized programming is the starting point for the overall classroom program. Based on the prior assessment data, consideration of several factors or steps are involved:

a. A thorough understanding of the child in terms of developmental levels, learning readiness skills and social-emotional development.
b. Selection of appropriate, realistic goals or tasks of learning in several functional areas based on an analysis of emerging skills, on an awareness of the child's interests, on an understanding of sequences of goals or skills and on the use of relative strengths to work on weaknesses.
c. Selection of the most appropriate materials and methods for teaching each activity. Commercial educational materials are potentially useful but typically need to be adapted to the psychotic child's unusual learning characteristics. The optimal teaching method is likely to vary dependent upon the requirements of the task and should take into account the child's imitative skills, his preferred modalities, his understanding of language and gestures, his memory for routines and need for repetition and his distractibility and tolerance for impingement.
d. Anticipation of potential behavior management problems and roadblocks to effective training. A basic assumption of the model is that the selection of appropriate teaching tasks geared to the child's level of functioning reduces the likelihood of management difficulties. In addition, teachers need to be skilled in operant or behavior modification practices.

Group teaching allows for social interaction experiences and helps develop attending and waiting skills. Different youngsters may at times be paired with others depending on areas of strengths and weaknesses. The scattered developmental levels and varying learning styles require careful planning of a group lesson. The following steps are considered in the design of a session:

1. Establishing individual goals, task analyzing then obtaining objectives.
2. For each child, several activities should be considered for meeting the objectives.
3. Those activities that have the most potential for meeting most objectives across children are selected for the group activity.
4. The activity is taught with adjustments made to best "fit" the objectives and unique learning and behavioral characteristics of the child.

Certain activities enable the entire group to participate together including snack time, morning or afternoon circle songs or games, physical education exercises, lunch and arts and crafts. The daily schedule typically reflects a balance of intensive individual instruction and more relaxed social and self-help activities.

For TEACCH children who are not too impaired, eventual return to a normal setting is anticipated. However, most of the children are too impaired for this expectation. Most of the autistic or psychotic children continue to need self-contained classrooms and appropriate support programs through adolescence. There have been several positive experiences of youngsters placed part-time in a normal classroom while still enrolled in the TEACCH program; other youngsters have moved on to less "restrictive" settings such as educably retarded or learning disabled classrooms. Nevertheless, an educational system committed to serving this population must reckon with the reality that the chronicity and severity of the handicapping conditions demand long-range planning of services.

5. *Parent participation:* Parents are actively encouraged to become involved in the classroom programs. Depending on availability of time and other resources this involvement can range from volunteer teaching on a regular basis to regular communication with the teacher. Parent groups are organized at both the Center and classroom levels and when meeting regularly they become sources of emotional support as well as educational programs. As noted earlier, parents in the state have been social action proponents.

Implementing the Model

A PROCESS—NOT A PRODUCT

All too often, the measure of success of a program is based on statistics highlighting numbers of cases served, percent of positive outcomes or "cures", range of services offered, research publications, etc. Though useful as a rough gauge of effectiveness, they usually fail to convey the essential underpinnings of a program. Experience with the TEACCH model (including the pioneering years of the earlier Child Research Project) has supported the belief that a process orientation meets the needs of such a service delivery system better than a reliance on fixed, tangible products.

Process is an elusive concept but might be elaborated in the following ways:

1. As has been repeatedly emphasized, the primary commitment in the program has been to focus on individualized needs, whether in the clinic, class-

room or community. A commitment to individualism means that the concerns, expectations and resources of the target population must be given top priority. Often this requires a suspension of one's own wishes in order to respond to the other's needs. It means that each case or set of circumstances is considered unique and demands a fresh perspective. The development of the diagnostic and intervention strategies of TEACCH reflects a willingness to be flexible and adaptable.

Individualization occurs at the administrative decision-making level as well as the clinical-educational level. Responses to community needs and shifts in program policy are made with a comparable commitment to address individualized concerns.

2. The evaluation of the program has been a process that in some sense mirrors the view of the psychotic child as a developing (though handicapped) organism. To understand the complexities of the child and his family requires direct experience working with the child and struggling with the families' concerns. A repetition of these experiences with a variety of families broadens the perspective of a staff member and results in growth and professional development. Knowledge of techniques and maturity of judgment expand and are refined with each individual; a cumulative effect occurs and the program as a whole takes on an added dimension. In the same manner that the teaching of parents and the children builds on their fundamental strengths and competencies, staff members are encouraged to utilize and to capitalize on their basic skills and personal qualities.
3. Evolution implies change and a commitment to change is another aspect of the process orientation. As noted earlier, the program has undergone repeated expansions with the addition of classrooms and clinical centers. Change has occurred in the addition of newer teaching techniques such as sign language. The relationship with parents has shifted from the helping professional to a collaborative role in the planning of services for autistic children. The awareness of the need for extension of services to adolescents has required investigations into and experimentation with different program models. The need for different service delivery patterns for rural and urban areas has required adjustments in both staffing and classroom service patterns.

An illustratinon of the adjustment is seen in the way classroom services are delivered in larger urban areas (e.g., the cities of Charlotte and Raleigh) as opposed to rural settings (e.g., the eastern coastal plain and the Appalachian Mountains in the west). A single classroom is sufficient to serve the metropolitan areas for children up to the ages of 10 to 12 years of age. All children live within a relatively close distance within a single LEA and often utilize the regular special education transportation network. Enrollment and the securing of support services are relatively uncomplicated in these urban settings.

The rural areas have proven more difficult to serve. Children in a coastal plain classroom (e.g., Elizabeth City) reside in up to five or six counties at a given time. In one location, the school officials volunteered to jointly fund a second aide so services could be extended. Although cooperation has been excellent, much effort is expended in arranging and maintaining communications with the several LEAs involved. In the western mountains, where the topography separates people and hinders travel, it has not been possible to provide TEACCH classes for the isolated rural youngsters. A psychoeducational therapist from the Western TEACCH Center has helped establish an outreach program to children and their families via direct home visits, consultation and training to local educators, day care workers, etc., and workshop experiences for groups committed to delivering service to the severely handicapped.

STAFF SELECTION, TRAINING AND SUPPORT

Although specific responsibilities vary according to staff role, several general characteristics seem essential to satisfactory job performance:

1. A developmental orientation toward children; as stated previously this is a fundamental concept of the TEACCH model. For the staff person it involves a knowledge of normal processes of child development and a recognition that the psychotic child can be understood in terms of delays, irregularities, and deviancies in those processes.
2. An ability to make good observations and draw meaningful conclusions based on an awareness of and sensitivity to the child and his environment. This implies an openness to varied information and a rejection of narrow assumptions about behavior and learning.
3. An ability to make decisions, often without the benefit of time to reflect. In the clinic and classroom, events and situations demand immediate action and sound clinical/educational judgment. Certainly a mastery of techniques and thorough knowledge of the child are essential, but the actual implementation of a plan requires a decisive, assertive individual.
4. An understanding of human relationships—the ability to communicate and to relate to both children and adults. Intense involvement with children who characteristically are unaffectionate can be frustrating and unsatisfying. Although it is rewarding to see developmental progress, the source of greatest satisfaction often comes from

interactions with colleagues and parents. Empathy with the parents' feelings and perspective, coupled with their own daily experiences, sharpens teachers' sensitivity to the needs of both the child and his family.

Selection procedures

Recruitment and selection of personnel is a joint effort of TEACCH and LEAs for teachers and aides and TEACCH and the University of North Carolina Personnel Department for psychoeducational therapists. Although relevant educational and background experiences are prerequisites, candidates must demonstrate competencies in a "work sample" situation conducted at the regional Center.

Candidates are initially screened at the local levels; usually the applicants who have prior knowledge of the program or a special interest in the field are most highly motivated. Those who seem best qualified from the initial screening are asked to spend 10-15 minutes working with a psychotic child after a brief period of observing a therapist work with the same child. The candidate is expected to use that time to familiarize himself or herself with the child, try out various activities and draw conclusions about the child's developmental functioning and educational needs. These impressions and conclusions are then written up in a brief report.

Applicants also spend time interviewing a parent with the objective of learning about parent concerns and expectations. The ability to comfortably relate with an adult and sensitivity to the parenting role can be judged. Again a report is written summarizing the session.

This unique screening procedure has been extremely helpful in selecting appropriate candidates. On paper and often in personal interviews, one applicant might seem equal to or stronger than a competitor. After observing the "work sample" there is usually good agreement between clinical director and staff for identifying the most suitable candidate. Despite the anxiety this procedure generates for the applicant, few, if any, have ever complained that it was unfair; most have expressed appreciation for the experience.

Teacher qualifications and responsibilities

When the program was initiated in 1972, certification standards were more relaxed than they are today. Fewer people were available and no one was specifically trained to work with autistic children or the TEACCH model. Individuals possessing those general characteristics and able to do well in the staff selection procedures (see above) received basic training and functioned well as teachers. Support from the Centers and parent involvement provided the encouragement to continue to grow professionally. Full certification was not necessary and applicants were welcome from academic areas emphasizing child development, especially if they had relevant experience. This policy has shifted within TEACCH for three reasons: (a) state certification legislation; (b) availability of increased numbers of qualified applicants; and (c) TEACCH now assists in the provision of certification and certification renewal.

Touched upon in an earlier section on the classroom program, the range of teacher responsibilities is summarized:

1. Establishing and maintaining a total day educational program for autistic children in accordance with the general philosophy and procedures of the TEACCH model.
2. Supervision of an assistant who actively collaborates and shares teaching activities.
3. The planning, coordination and execution of an individualized educational program for each youngster; this program pertains to both "one-to-one" and group teaching sessions and should cover all areas of developmental functioning, especially communication and behavior.
4. Scheduling and carrying out regular conferences with parents to review their child's progress and to assist with home concerns; encouraging and supporting active parent participation, including in-class volunteer teaching, parent training sessions and parent group meetings.
5. Preparation of regular progress reports detailing goals and activities of the previous month (See Appendix D): completion of the American Association of Mental Deficiency Adaptive Behavior Scales twice a year; relevant data collection, especially procedures designed for reducing undesirable or highly disruptive behaviors.
6. Serving as resource for non-TEACCH students, placed in normal classrooms or more mildly impaired groups, who might benefit from language training or another aspect of the more highly structured TEACCH class.
7. Meeting routine obligations expected of other teachers within the local school such as bus duty, attendance at staff meetings, etc.

Basic training

New staff—clinical directors, therapists, teachers and assistant teachers—are required to participate in an initial two-week training program conducted by TEACCH. Training is designed to (1) provide the trainees with an orientation to autism and goals and philosophy of the TEACCH program; (2) to familiarize them with diagnostic, educational and behavioral techniques appropriate to the population; (3) to sensitize them to issues in parent work and staff relations; (4) to prepare them (especially classroom staff) for those first days when full responsibility for running a program becomes a reality.

The training program focuses on direct experiences working with children in supervised diagnostic and teaching sessions. Ample time is afforded for discussion of these work sessions. Didactic seminars are given on special topics such as behavior management and language development. The trainee is expected to use spare moments to read handouts and reprints, design individual education plans or write up a testing or teaching session. Although the emphasis of training is on the role responsibilities of the particular job, trainees are given exposure to the expectations and duties of other staff positions.

The North Carolina Department of Public Instruction (DPI) has fully cooperated with TEACCH's training efforts. Recently, DPI provided approximately 47% of the costs for training; this included salaries for the demonstration classroom staffs, transportation to students, stipends for the trainees and travel expenses for the trainees. Moreover, DPI certifies teachers in the state who have been through the program.

Training is always held in a local education administration school. The teaching staff for the LEA and children enrolled in the school (as well as their parents) are key participants.

The cost for the basic training in 1976 amounted to approximately $140 per trainee, not including salaries, which vary according to position. In the future, trainees can receive graduate credits from the University of North Carolina at Chapel Hill.

Ongoing support

The theme of continuity of care and ongoing support has been an inherent part of the TEACCH program and its predecessor, the Child Research Project. Just as it is recognized that families with psychotic children need the assurance that logistical and emotional help is always available, an equivalent system of supportive bonds is necessary for teachers and therapists. This is readily maintained in the Centers where staff members share cases, perform comparable functions and meet regularly as a team to review their work. This level of support to the classrooms is more difficult to sustain, primarily because of the relative isolation of these programs from the Centers. However, support is provided by regular visits from the Center staff to the classrooms.

Within the classrooms additional sources of support come from the close working relationship between teacher and aide, contacts with parents, occasional visits from other professionals and students, and staffs of the local schools. Specifically, for a newly established classroom, following the basic training, weekly visits are made by the Clinical Director and therapists during a two-month period. These visits are supplemented by phone calls and written consultation reports. The frequency of contacts gradually decreases until a once-a-month schedule is reached. Phone calls and follow-up reports continue. In addition a two to three day mid-winter in-service training program for the Center and classroom staffs is held.

The consultation or liaison work from the Centers to the classrooms has as its major goal to meet the needs of the teaching staff as it implements the program. Consultation takes different forms: specific suggestions about a child's curriculum, brainstorming about innovative approaches, demonstration by a therapist of an activity or technique, helping with a parent conference or session, an open and frank discussion of a problematic area or source of emotional stress. Regardless of the actual content of the consultation sessions, the crucial determinant of the continuing success of the classroom program is the measure of confidence and respect staff members convey to each other.

RELATIONSHIPS WITH LOCAL EDUCATIONAL AGENCIES

Background and contractual arrangements

Given the mandate to establish educational programs for autistic children, it was decided to locate the programs in local public school facilities for the following reasons:

1. Public schools represent the mainstream of American society; families whose psychotic children were previously excluded from educational services were entitled to participate equally in the system.
2. Greater opportunities exist for more normal interaction with other children and adults in a public school setting.
3. A wider range of learning experiences exist in a public school given the access to physical facilities, curricular supplies, personnel and general resources. These are available at much less cost than if efforts were made to duplicate the resources in a separate or private facility.
4. Placement in a public school reinforces in the mind of the community the recognition that responsibility for the proper education of severely handicapped youngsters ultimately resides at the local level. At the same time, the successful development of such a program generates a sense of pride and accomplishment for the community.

Having made this decision, TEACCH approached the LEAs with a proposed contractual arrangement. LEAs were selected on the basis of children identified by the original Child Research Project, the size of the population and interest shown by the local administration. Although there are minor variations across LEAs, all contracts contain these major components (See Appendix F for sample contract):

1. The classroom staff is employed by the LEA, but selected through the joint efforts of TEACCH and

the LEA. Evaluation of performance, including termination for unsatisfactory work, is likewise a mutual effort.

2. Enrollment of students in the class occurs only after a comprehensive diagnostic evaluation at the nearest TEACCH center.
3. The rights, privileges and responsibilities normally provided LEA personnel is accorded to TEACCH classroom staff.
4. The philosophy of and specific procedures employed in the classroom are under the direction of the TEACCH Director of Educational Training. This responsibility can be delegated to the Center Clinical Director, principal or others.

The implementation of the contract and the maintenance of satisfactory working relationships involve regular contacts between the TEACCH Director of Educational Training and local key administrators, whether superintendents, assistant superintendents or directors of special education.

Funding

The North Carolina General Assembly allocated sufficient funding to start eleven classrooms (along with three Centers) during the 1972-1973 academic year. These programs have continued without interruption. Although most expenditures are made by the LEAs (for example, teachers are on the LEA payrolls), reimbursements are made by TEACCH on a quarterly basis. Staff training, travel expenses, curricular supplies and equipment are paid by TEACCH.

With the recognition of the success of these early programs and the pressure for increased appropriate educational services, LEAs in other parts of the state began requesting assistance from TEACCH in establishing new classes, ESEA Title VIB funds were available for classrooms in 1974 and the contractual format was again followed with two important distinctions from the original eleven:

1. Since funds went directly to LEAs there was no need for reimbursement from TEACCH;
2. The LEAs pay to TEACCH an amount that covers the costs of training and ongoing consultation. These funds enable TEACCH to hire additional staff to fill the increased service needs generated by the new program.

There are currently six Title VIB funded classes under contractual arrangement with TEACCH. These contracts are supplemented by a Memo of Agreement on file with the State Department of Public Instruction spelling out in detail the services provided (See Appendix F; also Appendix G for a sample End-of-Year report on a Title VIB supported program).

A third source of funding for TEACCH classes comes from local school budgets. In North Carolina, the major portion of public education is financially supported by the state. Under certain circumstances, local governments allocate local revenue resources to upgrade or increase educational programs. Two communities have utilized these monies to establish a program for psychotic children. These LEAs are responsible for staff salaries, materials and related costs, but not for consultation and training costs. Similar contractual arrangements are in effect.

Costs

During the last academic year the cost of serving children and their families in a TEACCH classroom was approximately $2255 per child per year. This compares with an average cost of about $1200 per child per year for non-special education programs in North Carolina. Statewide figures for special education costs in the state are not available.

Of this figure approximately $1601 (71%) is applied to direct services to children and their families (teacher and aide salaries, supplies, etc.) and about $654 (29%) to support services (in-service, travel, center costs).

Difficulties and challenges

Perhaps the greatest challenge to the development of a viable classroom program has been the reconciliation of a model based on individualization and the pressure of bureaucratization that is an inevitable part of any large system. Considerable effort has been spent to minimize the drift to bureaucratic uniformity. With DPI and LEA cooperation and support, TEACCH has been allowed to develop the classrooms' individual strengths and style. Specifically, teachers and parents are brought directly into the decision-making process; parents are encouraged to be advocates for their children; rules and regulations are flexibly administered (e.g. length of school day, required number of hours and days in attendance, types and frequency of field trips, age of children served) to best fit the needs of the children and families. Finally, TEACCH enjoys a certain freedom by being located within a University setting; as an outside program, it cuts across other state agencies, including public education, enabling it to directly provide needed services without being engulfed in a bureaucratic network.

A particularly delicate situation involves the pressure on teachers to handle split or dual loyalties to TEACCH and the LEA. Since the staff is employed by the LEA, they report to the building principal. As members of the community, they identify with their professional colleagues in the school. At the same time, their training, supervision and support come from the TEACCH staff. Fortunately, the teachers, local administrators and TEACCH personnel have been sensitive to the needs of each other and "serving two masters" has strengthened, rather than diminished, the programs' effectiveness.

Transportation, a perennial headache for public school educators, was especially problematic for autistic children because of the low incidence of the disorder, the participation of several LEAs for a single classroom, and the need for special adult monitoring for many children. Resolution of this problem occurred with aid-in-lieu of transportation made available through the state DPI. Parents, friends or contracted drivers provide transportation and are reimbursed for travel costs.

In-service dates often vary across LEAs and since TEACCH is involved in many local systems and conducts its own training, conflicts arose. TEACCH accommodated by holding basic traning prior to the opening of the school year. In turn, the LEAs adjusted by permitting the teaching staff, in accordance with the contractual arrangement, to attend mid-year workshops and other special sessions conducted at the Centers.

Finally, the involvement of parents in the educational process, either by assisting with teaching or otherwise collaborating in the child's special education was an unfamiliar experience for most schools and for the parents themselves. The concept of the parent as participant in the educational process has not yet been fully understood by the public school systems. But with new federal guidelines requiring parent collaboration in the development of individual educational programs (IEPs), school officials and personnel are becoming increasingly interested in making parent teacher collaboration work for the benefit of the child and his family.

RELATIONSHIPS WITH OTHER AGENCIES

As both a clinic and classroom program TEACCH has developed and maintained ties to a variety of agencies that serve handicapped youngsters. Referrral sources were mentioned earlier. A primary source of referrals has always been the developmental evaluation centers that identify disabled children and recommend treatment services. More recently, referrals are being increasingly made by public schools who are seeking additional outside input in educational planning or development of a different service for psychotic youngsters currently enrolled in an existing program. TEACCH endeavors to maintain a close working relationship with its referral sources by keeping them updated with written reports or checking back if a significant new development has occurred with a case.

There are many programs and services that have been extremely helpful to families in the TEACCH program. It is a basic policy that TEACCH continue to provide service to families until a satisfactory alternative program has been found. In practice, this means that if a day program is recommended (and a TEACCH classroom is not available) efforts are made to identify a local school, day care facility, etc., willing to work with the youngsters and the family. The range of services and agencies that have been involved and have collaborated with TEACCH is as extensive as the needs of the children and their families, whether medical, educational, respite or recreational.

At times agencies that have accepted psychotic children have required back-up support or training to adjust their particular services to this unique population. Increasingly TEACCH has become active in providing such consultation and education to outside programs. In fact, the Western TEACCH Center is extensively involved in outreach activities, not only working in the homes of the families but giving workshops for critical community people. Across the state in-service training and short-term (one to three months) or continual consultation have been provided to non-TEACCH public school classrooms serving a psychotic youngster, developmental day care programs, mental health centers, group homes, regional resource centers, DPI and their training programs, residential institutions and summer recreational programs. Consultation to out-of-state programs has also been available.

Finally, TEACCH personnel have been involved in training undergraduate and graduate students in various disciplines and in teaching University courses and seminars. The staff has also been active on national, state and local committees such as the Developmental Disabilities Task Force, DPI re-certification policy planning and Parents and Professionals for Handicapped Children, a coalition group active at the legislative level.

Research Component

In many service programs research is confined to administrative review or regarded as being in confli with clinical requirements. These limitations have been avoided in Division TEACCH by building an active research component (the Child Research Project) from the outset and from which the State Program evolved. Having the Program located in the Psychiatry Department of the School of Medicine made it conducive to research. Research funding was primarily provided by federal agencies (National Institute of Mental Health and Office of Education). Most important, however, was that most of the research was derived from clinical experience and in turn relevant to program activities. This is reflected by the references in this presentation and detailed in Schopler (1974). When staff and family recognize the relevance of research to their clinical needs, it can also be a stimulating and morale boosting supplement to their daily routines.

Conclusion

A state wide program for autistic and related communication handicapped children and their families has been presented. The TEACCH model has derived from experience with autistic children and their parents and joint efforts to develop adequate services in North Carolina during the past 12 years. Although this process continues, the following issues have clearly emerged and deserve re-emphasis:

1. It is possible to develop a Program that included centers for individual counseling with the special education and behavior management of developmentally handicapped children (like the autistic) and their families. These children can also be provided with special education services within the public schools, thus sharply reducing the need for institutionalization.
2. Such a program can provide the relatively homogeneous learning environment required by these children by integrating special education efforts at home and at school. This is accomplished by the appropriate involvement of parents in both home and school teaching.
3. The individualized curriculum and management required by these children can be fostered by special administrative organization, designed to maximize the direct relationship between therapist-teacher staff and families. This can be done with specially trained staff employed in a Program organized across certain state agency functions including Public Instruction, mental health, and public health. This organization is possible when good cooperation with these state agencies is obtained.
4. Both special education curricula and behavior management are formulated within a developmental framework. This is necessary to work out appropriate adaptive skills for children characterized by irregular and inconsistent mental functions.
5. The needed individualization can be achieved by avoiding the use of any one special education or treatment technique for all children. Instead, a developmental orientation offers clear guidelines for how individualized programs are developed.
6. Flexibility and openness to consider new treatment alternatives as they become established make it possible to modify the program to changes in treatment knowledge and community services.
7. The close collaboration with parents in the treatment situations facilitates collaboration with parents for developing new services as needed.

The future of TEACCH is likely to reflect its past in program responsiveness to its constituency. Shifts have occurred such as collaboration in the establishment of a group home, classes for adolescents, summer camp and summer recreation programs. With an increasing number of states and regions concerned with developing services for their autistic and developmentally disabled population, TEACCH has played an increasing role in consultation and education. Hopefully, to the extent that the model has general application to other programs, the experiences of TEACCH will continue to be shared.

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Controlling Academic and Social Performance Using an Instructional Delivery Approach

Edward E. Gickling, Ph.D

Like other areas of exceptionality, a full range of intervention options are required to deal with the special problems of the emotionally handicapped. For those who are more severely involved, services need to be provided ranging from forms of incarceration and hospitalization to alternative and special day school programs. For the less involved, however, the options are usually confined to the parameters of being placed in a full-time special education class, of being sent to a resource room, or remaining in the regular classroom. It is to those of you who attempt to deal with the behavior problems of students in these classroom options that this paper is primarily addressed.

For the student in conflict, it has been observed that instructional deficiencies and inappropriate classroom conduct frequently parallel one another. Exactly which problem appears first is difficult to say. What has been noted, however, is that the appearance of one type of problem will likely be accompanied by the other; and that the two become more severe as the student grows older (Bettelheim, 1961; and Bower, 1971). The increasing discrepancies between classroom demands and the ability to produce merely compounds the problems for poorly performing students; but the results are usually the same—an avoidance and distaste for school and what it entails and a displacement of energy in inappropriate channels.

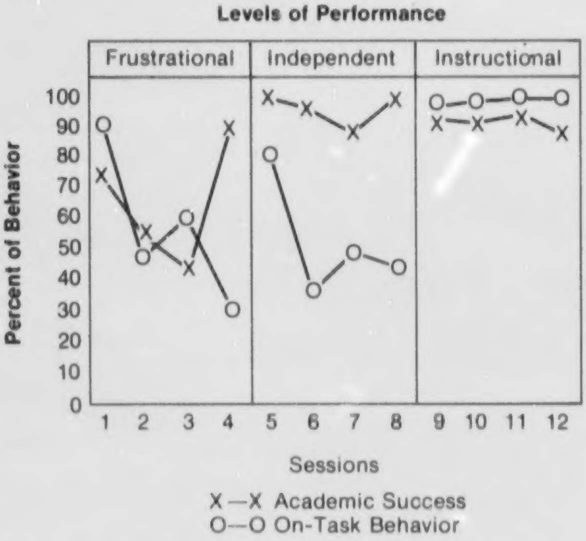
The situation just described too often results in teachers spending a disproportionate amount of time reacting to conduct and disciplinary problems at the expense of teaching. Understandable as it may be, it is unfortunate that such a large expenditure of time should be given to curtailing abuses. What causes this condition to exist, and why is it so pervasive within the public schools? To place blame on sources such as poor teaching, inappropriate classroom structure, insufficient resources, non-cooperative and nonproductive students, etc. would accomplish very little since the most consistent problem facing these students would go unresolved. Instead of expending excessive energy on these factors, I purport that we as educators more systematically address the problems of curriculum, or more specifically, the myriad of daily classroom assignments asked of each child. I further purport that we would do well to expend our initial energies in correcting curriculum ills as opposed to social ills. Look around at what happens to children in school. Children who are behavior problems are for the most part the "Curriculum Casualties" of school.

As educators we used to work on the assumption that deviant behavior must be brought under control before academic progress could be made. We now have evidence to refute this commonly held belief and have come to realize that overall progress is better achieved by capitalizing upon academic and social progress simultaneously (Galvin, Quay, and Werry, 1971). To do this calls for interventions which emphasize behavior change on the one hand and the management and mastery of instructional materials on the other. Student behaviors related to both of these dimensions must reach acceptable standards for classroom programs to be successful.

Since social interventions have their limitations within the classroom, the importance of appropriate curriculum becomes even more paramount, as does the concept of maintaining each student at an instructional level within the curriculum. As educators we know that a curvilinear relationship exists between students' abilities and the difficulty of materials they are called upon to master (Soar, 1972; and Brophy and Everton, 1976). Materials must be sufficiently familiar yet contain appropriate margins of challenge to bring out the best in students. When they are too difficult or too easy students' performance become limited. These performance patterns across three levels of difficulty, and their accompanying social patterns are hypothesized below.

If the hypothesis is correct, students' behaviors under frustrational conditions will show two things: first, considerable variability or fluctuation in academic and on-task behavior; and second, a decrease in on-task

FIGURE 1. Hypothetical Situations Wherein Students Are Matched With Materials Which Are Too Difficult, Too Easy, and Instructionally Appropriate



behavior as academic behavior falters—generally the patterns for the two variables parallel each other. Under independent conditions one can expect a pattern of high academic success associated with relatively low levels of work expenditure or effort. Under instructional conditions, however, when the ratio between task familiarity and task difficulty is right, consistent and high performance can be expected in the form of on-task and academic behavior.

Of course this information is not new. As educators you have probably been aware of it for some time and you have probably been advocating that behavior problem children be maintained at an instructional level. Then what is the problem? Look again at sessions one through four in Figure 1. The degree of difficulty of materials in session one appeared appropriate as seen by relatively high percentages of on-task and task success. In sessions two and three, however, the success rate has decreased to approximately 50 percent and was accompanied by a corresponding decrease in on-task behavior. Session four illustrated an attempt to adjust for the degree of difficulty observed in sessions two and three. The results of this session show that an overadjustment had been made and that the material was too easy—this was indicative of an increase in off-task behavior accompanied by a fairly high task success score.

The problem that has been demonstrated here is basically one of curriculum variability, or more specifically, the variability of item selection within assignments themselves. For students whose performance remains at essentially first or second grade level, and who are constantly frustrated by their assignments, the process of making an appropriate match between materials for the child and the skills of the child is extremely tenuous. Most of the problem in making the "match" rests with the procedures we use to determine the level of difficulty of the materials and the level of student function. In both cases the procedures used to calculate "level of ..." are basically normative, and are at best relative approximations of difficulty and/or skill. When you stop to realize that the standard error of measurement of these procedures actually exceed the range of skill of most poorly performing students then you get some idea of the variability within the "match." Compound this with the four sessions of Figure 1. Because of these and other problems I say that there isno such thing as an accurate "level of difficulty" or "level of function" as typically used by educators to facilitate the match for most poorly performing students. Since there is virtually no academic reprieve you can expect a wide variety of inappropriate outbursts from these students.

Let me present one case in particular to illustrate the point just made. I think you will see Rick's case as being rather typical of the behaviors of problem children in schools. He was an eight year old of normal ability, but was unable to keep pace with his third grade classmates. His behavior was characterized as defiant and unmanageable. He demonstrated hostility toward school work in the form of temper outbursts, pouting episodes, and verbal and physical refusals and withdrawal from work situations. He frequently "floated" about the classroom, seldom attended to school work, and was often in confrontation with other students. By the third grade, his behaviors had deteriorated to the point where he was referred as a learning and behavior problem to a diagnostic center for evaluation.

The following demographic data showed his overall level of ability, his general level of reading function, and one of his reading prescriptions. Instead of a third grade basal reader, the first book in the *Jim Forest Reading Series* was prescribed. This book supposedly matched his general level of reading skill. Exactly how well he performed on the prescription can be seen below. His initial reading performance on the first three paragraphs of the book looked like this. (All italicized words were *unknowns* and all underlined words were hesitant responses).

Jim Forest and the Bandits
(Rambeau J. & Rambeau, N.)

"*There is a* forest far up in the *mountains*. It is called Big *Pines*. *There* is a little *store there*. *There* is a *ranger* station *there* too. It is called Big *Pines Ranger* station.

Jim lives at the *ranger* station. He lives *with* his Uncle Don. Jim's uncle is a forest *ranger*. A *ranger's job* is a big one. He looks out for the forest. He looks out for all the things that live in Big *Pines*. One day

Jim and the *ranger went* into the forest. *They* took *their horses. Star* is the *ranger's horse.* Big *Boy* is Jim's *horse.*

Jim and Ranger Don *were away* all *morning.* At *last they started back.* As *they came* down the *mountain,* Jim *said,* "Look! you can see the *ranger* station from *here." Ranger* Don look out *over* the trees. "Yes I can see it. I can see the *barn* too," *said Ranger* Don. *Then* the *ranger* looked *again.* "did you *close* the *barn* door Jim?" "Oh yes, Uncle Don. You *said* to *close* it, and I *know* I did," Jim *said.*

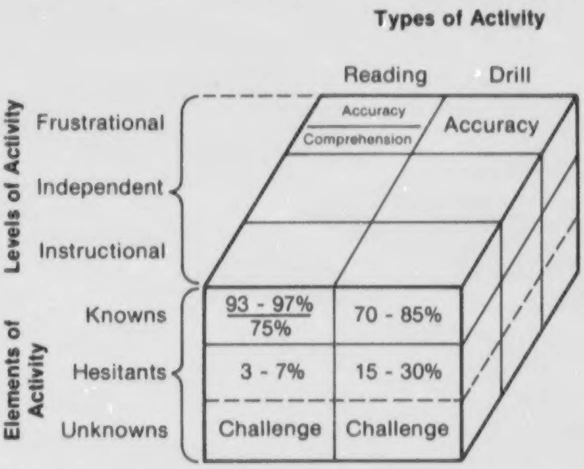
Obviously what had been thought to be an effective match between Rick's reading ability and the first paragraphs in *Jim Forest and the Bandits* had resulted in a frustrational reading situation. Even though a prescription had been made, a one-to-one correspondence had not been achieved between the skills of the student and the demands of the reading task. The variability of the words within the selection had presented an unfavorable learning experience and merely added to his poor performance and task avoidance. What had been anticipated to be an appropriate "match" had broken down; neither the supposed "level of difficulty" nor "level of function" had resulted in an appropriate match.

The problem was not as simple as finding other reading material. With a normal yet older child whose reading performance is so limited, it is almost impossible to find the "right" materials. What was needed was a more systematic way of accounting for and adjusting material that would be sensitive to the precise skills of the boy. As in Rick's case the problem was one of modifying what material was available to the point where it was compatible to his skills. In order to make these adjustments, material prepared for Rick was made to conform to a set of criteria as specified below.

Space will not permit an elaborate treatise explaining the logic, formation, and specific components associated with the model. But in the space allowed it is sufficient to say that the model provides a structure whereby the degree of difficulty within each assignment can be systematically controlled to assure a given percentage of success versus a percentage of challenge. As the model attempts to show, the problem of difficulty can best be accounted for by controlling the *ratio* of known to challenging elements in order to maintain each assignment at an instructional level for each student. The ratio for reading is 93-97 percent known elements compared to 3-7 percent challenge; and for drill, 70-85 percent knowns versus 15-30 percent challenge. An element is simply defined as the smallest complete unit of a task, i.e. a letter, sound, word, number, fact, etc., depending upon the nature of the task.

When applying the use of the model to poor performing students we realized two things: first, that teaching materials which are chosen must complement what the teacher feels needs to be taught; and second, that the materials must be within the grasp of the child. In Rick's case we felt that the first condition was appropriate and that Rick could profit from the *Jim Forest Series.* In order to provide the second condition, however, had to modify the content of each succeeding paragraph to conform to the criteria of an instructional level—first through drill activity and then through reading content itself. Examples of the types of transitional paragraphs or the modified content used to provide an instructional level specifically for Rick, as well as his accompanying responses to comprehension questions follows next.

FIGURE 2. Delivery Model for Instruction



(Gickling, 1975)

Uncle Don

Uncle Don took Jim to the *mountain.* Uncle Don is a forest *ranger there.* He lives *on top* the *mountain.* He lives in the trees *on top* the *mountain.* He took Jim to look at all the trees in the forest. Jim looked up at all the big trees. He looked far into the forest at all the big trees.

Uncle Don Took Jim to the Mountains.
Did Uncle Don live *on top* the *mountain?* yes.
He took Jim to see the trees.
Is Uncle Don a forest ranger? yes.

Challenges
did
mountain
on
ranger
there
top
(77% known before Drill)

Big Pines

There is a forest far up in the mountains. The forest is called *Big Pines.* There is a little *store* on top the mountain. A ranger lives on the mountain. He lives at a ranger station. The station is called Big *Pines* Ranger Station. Jim lives at the ranger station. Jim lives *with* his Uncle Don. Uncle Don is a forest ranger.

The forest is called
Big Pines
There is a little Store
on top the mountain.
The ranger lives at a
Station.
The ranger station is called
_.................
Jim lives *with* his Uncle.

Challenges
called
little
Pines
station
store
with
76% known
before Drill)

Altogether, eight transitional stories were written and taught to Rick before efforts were made to have him actually read from the book *Jim Forest and the Bandits*. After drilling and reading these stories, the accumulative word pool had become sufficient to maintain him in the first few pages of the book. It was of continuing concern on his behalf to make certain that an appropriate instructional ratio was maintained for each succeeding page. The steady increase of his known words from page to page also helped to make it possible to keep him in the book once it was introduced. Once he began reading from the book, and began being exposed to the new words prior to seeing them in context, transitional stories were no longer necessary. He had become able to successfully read within the book and eventually complete the reading of the book.

How does one illustration relate to the subject of misbehavior? During four days of baseline observation, Rick's daily average on-task behavior amounted to only nine percent. His use of the remaining time consisted of episodes of task avoidance and noncompliance, such as wandering about the classroom, picking up and looking at nonassignment related material, not responding to the teacher's request to return to his work station, and a host of other assorted behavior patterns.

Rick's inappropriate behaviors did not occur, however, when his assignments were modified to conform to the criteria in the Delivery Model. Observations taken during his seatwork activity showed his being on-task more than 95 percent of the time under this type of curriculum format. This pattern of high on-task behavior maintained itself through 14 training sessions—the length of time the instructional ratio was enforced.

Rick's case, of course, represents only one illustration where the use of the ratio format corresponded to dramatic changes in both academic and social behavior. He is not alone in these changes, however, since similar results have been achieved with a variety of poorly performing student populations in a variety of educational settings (seek related research from the author). These patterns of behavior change have occurred with regularity and have created predictable situations, at least to the point where some degree of generalization has occurred.

As a challenge, I am led to believe that appropriate curriculum choices are for a large measure the antecedents to appropriate social change and not vice versa; and that our educational priority under most situations should begin by being more sensitive to the difficulty of assignments presented to poorly performing students. I also believe that the ratio of assignment difficulty can be controlled sufficiently to produce favorable antecedents and consequences so that learning and teaching are less painful. We have much of the educational technology necessary to control for the difficulty factor and with the use of the *Delivery Model for Instruction* we have one more technique for gaining an upper hand on the problems of assignment selection and variability. What I am saying is that we have the obligation to control the curriculum first and then to employ whatever means may be warranted to bring about social change. In the majority of the instances which I have seen within the public schools, the control of the former has also controlled the latter.

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The Bailey Program for Severely Disturbed Adolescents

Byron McDonald and Ann Evans

Introduction

The Bailey program is an educationally based program for severely emotionally impaired adolescents. It currently serves thirty students from the ages of eleven to sixteen. The staff goals are to develop an unconditional positive regard for each student and to reinforce in each of them their own worth as individuals. The goals for the students is to enable them to manage their own behavior so that they can become functioning, productive students. To reach that goal, a reality based behavior modification system is used. The staff and the system continually make the student aware of what is acceptable behavior, what is unacceptable behavior and what the consequences of each are. The system rewards the student with both tangible rewards and privileges for acceptable behavior and it denies rewards and privileges for unacceptable behavior. The staff provides a warm, supportive secure, caring environment for the students, which is the essential part of the system.

We believe that the program described within this paper has many advantages for local school systems. It is a program which can be implemented within any school system, which has a commitment to children with emotional problems. It can be done using a school system's given financial, administrative, human and physical resources. Costs are low and reasonable as compared to other programs for similar students. It's concept is consistent with the philosophy that it is the school's responsibility to provide an educational program as opposed to a treatment program. It provides a necessary step in a continuum of services a district must have under mandatory legislation.

This paper will describe the program in detail, the students served, its curriculum, as well as giving background information as to how the program was developed and the applicable state rules and regulations.

Background

MANDATORY LEGISLATION

In 1971, the State of Michigan enacted Public Act 198 which mandated Special Education programs for all handicapped children from the ages of 0-25 years. Prior to that time, the legislation had been permissive, allowing partial reimbursement to those school districts which chose to provide programs for handicapped children under rules and regulations developed by the State Department of Education. In addition to that resource, many Intermediate School Districts had passed Special Education millages which provided additional financial resources. With both State and Intermediate funding, along with local district funds, many school districts, including Pontiac, had developed fairly comprehensive programming for handicapped children, particularly in the elementary age range. The Mandatory Special Education Act, with it's accompanying rules and regulations took effect in the schools in the 1973-74 school year. The concept of Michigan's Mandatory Act is that every child, regardless of his handicapping condition has the right to a free and appropriate education. It is the responsibility of the child's school district (local education agency) to either provide that program or to see that it is provided. Included in the law is a due process section which gives the parent the right to fully participate in the referral, identification and placement process with a hearing procedure should the parent not agree with the certification or recommendations. When the Mandatory law took affect, there were four groups of handicapped students not previously programmed for within the public school system. They were handicapped students from the age of 0 to 5 years; handicapped students from the age 18 to 25 years, who hadn't graduated from a high school program; the severely mentally impaired, who had previously been in Community Mental Health programs; and the severely emotionally impaired.

PONTIAC

Pontiac is a city of 78,000 citizens located in the county of Oakland of the State of Michigan. It is an urban city located in a county of mostly suburbs of Detroit. It's industry is automobiles and trucks with both Pontiac Motors and GMC Truck Factories located in town. It's population is racially mixed with whites, blacks and latinos. It's economy, culture and housing are more similar to an industrial city than to a suburban community. The school system has an enrollment of over 21,000 students with 23 elementary schools, 4 junior high schools, 2 senior high schools and an alternative education secondary program. The district also provides a comprehensive adult basic education and community education program. The school district has been under court ordered cross district busing for racial integration since 1971.

IDENTIFICATION OF NEED

When the Mandatory law took affect, Pontiac provided fairly traditional programming for students with emotional problems. At the elementary level, school social work and teacher consultant support for students with mild problems, resource room and self contained classes for those who needed more support than could be provided in regular classroom programs. At the secondary level, there were school social workers, teacher consultants, guidance counselors and resource room programs. When a student's problems were more severe than could be dealt with within the available program, or when more support was needed to maintain the child in a public school program, the child was referred through the parents to the Community Mental Health Out-patient facilities or to the State Hospital for the emotionally ill, located within the City of Pontiac.

It soon became apparent under Mandatory law, that there was a significant group of children whose emotional problems and behavior were too severe to be handled within the resource room or self-contained classes the district provided. The behavior of the students could be described as hyperactive, aggressive with frequent displays of verbal outbursts against other students and/or teachers. This behavior resulted in frequent closure of classes or the implementation of a modified school day or placement on homebound services with no school attendance. All of the students had either received assistance from a Treatment program at the State Hospital and returned to the public schools, or referred to the courts, having received limited assistance and returned to the public schools for an education. All had been identified as eligible for Special Education Services as emotionally impaired. Most of the students demonstrated severe academic deficits, which complicated their emotional problems within the school. Many of the students either did not respond to the type of treatment programs offered them by the mental health or court facilities, or quickly reverted to their previous behavior patterns once the supportive environment and services were removed. This was due primarily to the severe longstanding nature of their emotional problems, which were precipitated by home and environmental factors. A second problem was racial, cultural and economic barriers between the students and those treating them. A third was lack of facilities and personnel to handle those referred. This area of unmet need, which under Mandatory law could not exist, prompted Pontiac to develop programs for severely emotionally impaired students. At the early childhood elementary level, an educational program was implemented for children with severe emotional problems using Federal funds. At the later elementary, secondary level, a program was developed and implemented, which is the subject of this paper.

PROGRAM DEVELOPMENT

Both school district procedures and the Mandatory Special Education Act with its rules and regulations determine how a program is approved once an unmet need is established. Under the law, it is the local district's responsibility to develop programs to meet the needs of the handicapped children within its population. This plan is incorporated into an Intermediate School District plan. The Intermediate School District has the responsibility to both develop and monitor a comprehensive plan to serve all handicapped children within its boundaries. There is a Parent Advisory Committee at the Intermediate level, which has an advisory role in the process. Once the Intermediate School District's plan is developed, it is submitted to the State Department of Education for approval. The State Department has an approval and monitoring role in the process.

When the population of students with severe emotional problems was identified, a program was developed to meet those needs by Pontiac Special Education Department under the leadership of William Wright, it's Director. This program was presented to the Assistant Superintendent and the Superintendent for approval. The Assistant Superintendent presented it to the School Board who approved the proposal. The citizens of Pontiac have been well served by a School Board and Superintendent, Dr. Dana Whitmer, who have recognized their responsibility to provide good quality programs for all Pontiac students, including those with handicaps. Once the School Board approved the program, it was included in the Intermediate School District plan, which was approved by the State Department of Education. This program was implemented with the start of the 1975 school year.

The Bailey School Program is the School District City of Pontiac's approach to providing an educational program for severely emotionally impaired adolescents. The program was developed based on several assumptions about the school's responsibility for providing programs for severely emotionally impaired students. First, it is our belief that it is the school's responsibility to provide an educational program for all emotionally impaired students. Treatment we believe, in terms of a theraputic based program or intervention, is the responsibility of the parent and in Michigan, the Department of Mental Health. It is the school's responsibility to assist the parent and child to obtain assistance. It is neither the role of the public school to provide intensive treatment, nor do they have the necessary financial, people or facilities resources to provide it. Second, it is our belief that most children given an appropriate supportive environment can manage their behavior sufficiently to, at a minimum, maintain themselves within a school setting, and for most to make significant social-emotional and educational gains. Third, it is our belief that if the school environment is made to be a positive, attractive place to be with a program designed for the student's needs, that his desire to be there will cause him to manage his behavior to maintain himself within that setting.

REFERRAL AND PLACEMENT PROCEDURES

Students are referred for consideration for the severely emotionally impaired program through the established referral procedures of the Special Education Department and the District. Each school has assigned to it, a Pupil Personnel Team, consisting of a School Psychologist, Social Worker and a Nurse. This team works with the building principal and teachers in identifying and working with students with needs. If, after alternatives have been tried and found not successful and Special Education Services seem warranted, the parent is conferenced with to explain the problem and the Special Education referral process. The child is then referred to the Special Educational Department for consideration for supportive services or programs. Other referral sources, apart from the Pupil Personnel Team are; Child Accounting Supervisors, Juvenile Court, Mental Health Agencies, parents, Special Education teachers or supervisors, other school districts.

Once the child is referred, a Teacher Consultant is assigned to the child to serve as Case Coordinator. The consultant's responsibility is to administer an educational evaluation to the child and to collect the following reports, psychological, social history, classroom teacher report, other pertinent data as available from the court, mental health agencies, private treatment facilities, medical doctors. Once the information is complete, the Special Education Supervisor is notified who then sets a screening meeting called an Educational Planning and Placement Committee Meeting.

An Educational Planning and Placement Committee is composed of the following personnel:

1. Administrative—including Special Education Supervisor, Building Principal or Assistant Principal.
2. Diagnostic—including psychologist, social worker, school nurse, teacher consultant, speech therapist.
3. Instructional—including classroom teacher, teacher consultant, remedial reading teacher.
4. Parent or Guardian, who must be invited on a case by case basis.
5. Others, such as agency or court workers.

The purpose of the committee is to determine first, the child's eligibility for Special Education Services and second, if the child is eligible, what is the most appropriate placement for the child. The committee also has the responsibility to determine what the goals are for the child in the affective, cognitive and psycho-motor areas. Included in the EPPC process is a due process procedure which protects the child's right in the process through the parent. The parent has the right to see all reports on the child, attend and participate in the EPPC meeting. There is a hearing procedure should the parent not agree with the committee's recommendations.

DEFINITION OF EMOTIONALLY IMPAIRED

The State defines emotionally impaired as follows:

Rule 6: "Emotionally Impaired" means a person identified by an educational planning and placement committee based upon a comprehensive evaluation by a psychologist and social worker, or a certified psychologist, a certified consultant psychologist or a certified psychiatrist and other pertinent information, as having one or more of the following behavioral characteristics:

- a. Disruptive to the learning process of other students or himself over an extended period of time.
- b. Extreme withdrawal from social interaction in the school environment over an extended period of time.
- c. Manifestation of symptoms characterized by diagnostic labels such as psychosis, schizophrenia and autism.
- d. Disruptive behavior which has resulted in placement in a Juvenile detention facility.

For the purposes of the Bailey program, severely emotionally impaired is defined as a child whose behavior is so severely disruptive or withdrawn that he cannot be placed in any other Special Education or Alternative Education programs. Alternatives must have been tried before the child could be considered for the program.

Program

SCHEDULE

The students are in school five and one quarter hours, which is the same as the Senior High Schools in the District. Their day is as follows:

7:45 to 8:15a.m.	Homeroom (Students are given contracts)
*8:15 to 10:15	Academics
10:15 to 11:00	Social Studies Mini Course
11:00 to 11:30	Lunch
11:30 to 12:10 p.m.	Academics
12:10 to 12:50	Prevocational Mini Course
12:50 to 1:00	Homeroom (cash in points)

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*Depending on the student's individual schedule, he/she has a 45 minute gym period during the day.

CONTRACTS

At the beginning of each day, a student is given a contract. Students may earn a maximum of 72 points each day. Points are earned and marked on the contract by the teacher every fifteen minutes, according to the following criteria:

1. Two points are given every 15 minutes for behavior. (Being a student)
   a. Hands to self
   b. Staying in room or class unless given permission to leave
   c. No swearing
   d. No name calling or teasing
   e. Following teacher direction.
2. A total of 6 points are given each period for starting (3 points) and finishing a task (3 points).
3. As a means of the physical education teacher or mini course teacher communicating the student's behavior to the homeroom teacher, the Leader to Distractor scale is used on the contract:

   Leader: Does all work assigned and follows directions of the teacher as well as taking the initiative to help the teacher without being asked.

   Contributor: Does all assigned work and follows direction of the teacher as well as helping the teacher or another student when asked.

   Participant: Does all work assigned and follows directions of the teacher. Does exactly what is expected.

   Observer: Does less work than what is expected by the teacher. Doesn't follow directions half the time.

   Distractor: Does work sporadically—most of the time distracting other students and preventing them from doing their work.

REWARDS

A bank book is kept by each teacher for each student. At the end of the day during homeroom, the student makes the decision to either save the daily points or to spend them.

LEVELS

Beside cashing points for daily tangible rewards, a total of points for the week are tabulated. The weekly tabulation determines the student's level. There are five levels to the program. Level 5 is the highest and provides the most responsibility and privileges. Level 1 is the lowest with no privileges attached to it. A new student enters the program at Level 3. It takes three weeks for a student to move up a level (except at Level 1 where it takes two weeks to move up.) It takes one week for a student to drop a level. The levels are as follows:

Level 1

Must complete assigned task in designated seat in all classes.
Bathroom, drinks at teacher designated break times.
Lunch in seat in room at 11:00 with 73% of morning points. If lunch is not earned by 11:15, will not get lunch till end of day.
Escorted outside of classroom.
No special privileges
Limited physical education program at staff discretion.

Level 2

Must do assigned task and may sit on one of two designated seats.
Earns lunch at 11:00 with 73% of morning points.
Must eat in room.
Escorted outside classroom.

Level 3

Breaks for drinks or restroom at teacher designated time.
May have choice of two assignments and choose place to sit.
Lunch is not earned, but must be eaten in room.
Can participate in special Thursday afternoon gym, if gym points are earned during the week.

Level 4

Able to sit where desired as long as it is not disruptive.
Able to substitute assignments.
More classroom responsibility (run A/V equipment—run errands).
May have morning homeroom and lunch in student recreation room.
Able to earn incentive swim day with 80% of points (Friday morning).
Can participate in special Thursday afternoon gym if gym points are earned during the week.

Level 5

All level 4 privileges.
Able to help teacher plan work, sit where desires, more classroom responsibilities.
Able to go with staff when purchasing treats, lumber, leather, etc.

Monthly movie or trip to McDonalds for maintaining level for four weeks.

Each time a student moves up a level, they are rewarded with a trip to McDonalds.

Below is a list of percentage of points a student needs weekly for maintaining, raising or dropping a level:

Raises

Level 1 to Level 2: 2 weeks of 80% of weekly points
Level 2 to Level 3: 3 weeks at 85% of weekly points
Level 3 to Level 4: 3 weeks at 90% of weekly points
Level 4 to Level 5: 3 weeks at 95% of weekly points

Maintenance

Level 2: 73% of weekly points every week
Level 3: 78% of weekly points every week
Level 4: 83% of weekly points every week
Level 5: 88% of weekly points every week

Drops

Level 2 to Level 1: 1 week at 72% or lower
Level 3 to Level 2: 1 week at 77% or lower
Level 4 to Level 3: 1 week at 82% or lower
Level 5 to Level 4: 1 week at 87% or lower
Violation of school probation.

BEHAVIOR MANAGEMENT AND DISCIPLINE

Teachers handle inappropriate behavior in their room in the following manner:

1. Verbal direction is given.
2. Verbal warning with consequences is stated (point loss, chair restriction).
3. Chair restriction: If a student is persistent in exhibiting inappropriate behavior, he is given a chair restriction. This means that the student must sit in a chair which the teacher designates, completely quiet, nothing in hands for five minutes. He may not start earning points until the chair restriction is started. Refusal to take chair restriction is considered a serious offense and the administrator or team leader is notified.
4. If a student is out of control and creating dangerous situations in the room, then he is removed and the administrator or team leader assist.
5. A student may be put on probation for fighting or creating a severe disturbance. This means that if the student fights or creates a disturbance within 5 school days of the original incident, he will drop a level.
6. If a student has a weapon or potential weapon, the administrator is advised. The goal is to remove the weapon from the student in a safe manner.

GUIDELINES FOR CLASS CLOSURE

It is felt that in order to protect the rights of all individuals and assure a safe program for all students attending or staff working in the program, it must be clearly stated and understood what is acceptable behavior, what is unacceptable behavior and what will happen if unacceptable behavior occurs. The most severe discipline for unacceptable behavior is denial of attending school for a period of one or not more than five school days. This may be done if the following behavior occurs:

1. Assault or bodily harm to another individual while on the bus or during school time.
2. Carrying any type of weapon or object which could be used to do bodily harm to another individual or property.
3. Gross insubordination on the bus, in the classroom, or in between classes. Defined as failure to comply with adult direction after exhausted attempts by the adult or uncontrollable behavior resulting in continual disruption of class or activity.
4. Property damage, deliberate or malicious damage to another individual's property or school property.

STAFF RESPONSIBILITIES

Staff:

The Bailey Program operates currently with a staff of ten including:

1. Supervisor-Administrator (1/3 time)
2. Social worker/Team leader
3. Four teachers certified to teach the emotionally impaired
4. Physical Education Teacher
5. Three instructional aides

As a staff, we function under the concept of a team. We work cooperatively in making decisions about students and the program. There are weekly staff meetings. Below is a list of individual team member's responsibilities.

1. *Teacher:*
   a. Communicate with home about behavior and academic progress.
   b. Handle behavior in room unless an emergency.
   c. Develop individual curriculum plan for each student assigned to the room with the assistance of team.
   d. Daily log completed on students assigned to homeroom. Mark Leader-Distractor scale on contract for students in mini course and physical education.
   e. Initial assessment of students assigned to program.
   f. Define for aide, their duties during time assigned to them. Teacher orients aid as how to

handle discipline, instruction, give feedback as to performance.
   g. Inform team leader of status of supplies.
   h. Complete contract on child each period.
   i. Figure out weekly points on students assigned for level drop and raises.
   j. Keep bank book for each child assigned.
   k. Attend weekly staff meetings.
   l. When agreeing to work with a student teacher, help that student in planning units and activities.
   m. Document severe behavior, incidents leading to physical restraints (in addition to daily log).
2. *Team Leader/Social Worker*
   a. Inform parent of attendance or absenteeism.
   b. Discuss with parents in conference class closure or severe disturbances. Phone if necessary.
   c. Orient new students and parents to program.
   d. Communicate with all outside agencies.
   e. Provide individual and group therapy.
   f. Resolve transportation problems, scheduling transportation on new students.
   g. Coordinate use of aides.
   h. Represent program at Educational Planning and Placement Committee meeting.
   i. Assist teachers when they ask for help in creating curriculum and developing units.
   j. Ordering of supplies
   k. With help of teachers coordinate and evaluate use of student teachers.
   l. Attend staff meetings, assist with agenda.
   m. Assist teachers in dealing with severe behavior disturbances or emergencies.
3. *Instructional Aides:*
   a. Follow directions of teacher in charge.
   b. Provide teachers with feedback.
   c. Attend and contribute to weekly staff meetings.
4. *Supervisor/Administrator:*
   a. Overall supervision of program.
   b. Chair staff meetings.
   c. Make decisions on class closures based on advice of staff.
   d. Administer budget.
   e. Employ staff through personnel department, evaluate performance of staff.
   f. Conduct Educational Planning and Placement Committee Meetings on new referrals and students currently in program.
   g. Assist teachers in dealing with severe behavior disturbances or emergencies.

TEACHER SELECTION

Perhaps the most essential part of successfully operating a program for severely emotionally impaired students is the staff. No matter what system is used, it will only work if there are good, qualified people working in it, who have demonstrated a committment to emotionally impaired students and who have the necessary inter-personal and instructional skills to effectively follow through on that commitment. Judgement of persons who have that skill is very subjective, however, the following criteria is used to guide in teacher selection.

1. Certified by State in the area of emotionally impaired.
2. Well adjusted, positive persons.
3. Some prior positive experiences with emotionally impaired students.
4. Able to work with a team.
5. Understand and accept program philosophy and system used.
6. Able to serve as good models for students.

FACILITY

The program is housed in a facility near the center of Pontiac. The program occupies four large portable buildings. There are two offices attached to the portables, one used by the administrator, the other by the social worker. Three portables are used for academics with the fourth portable used part time for academics and part time as a student recreation room for those students on Levels 4 and 5. In the recreation room, there is a ping pong table and a pool table. We use a gymnasium at a school a few blocks from the program. Oakland University is used for the swimming program. The program has a bus assigned to it to transport students to gym or on field trips.

PLACEMENT OPTIONS FOR STUDENTS

Due to the variety of presenting problems of each student, the length of time a student spends in the program varies. Some students have been in the program almost two years, others only a few months. Options for students include other self contained programs housed in elementary or secondary buildings in Pontiac; Learning Centers in regular buildings; the vocational center, Teacher Consultant assistance in regular grades. Primarily, each student's program is individualized and integration back into other schools depends upon the student's skills. Some students have continued part time in the program and part time in other programs.

OUTSIDE AGENCIES

There are many outside agencies involved with children in the program. They are:

1. Department of Mental Health out-patient and in-patient facilities.
2. Private outpatient psychiatric clinics.
3. Juvenile Court.

4. Department of Social Services (some students are wards of the State).
5. Department of Vocational Rehabilitation.

Constant communication is kept with these agencies while a student is in the program. The social workers, therapists and probation officers are all included in planning a student's program, especially when a student is ready to leave or there is a significant change in the student's behavior.

FINANCING

The program is funded the same as any other Special Education programs are funded within the District. State membership funds and local tax money cover approximately thirty percent of the costs; State Special Education reimbursement pays for approximately fifty percent of the costs; Intermediate School District funds from a County Special Education millage cover about twenty percent of the costs. Reimburseable expenses of the program include salaries and fringe benefits of a Supervisor (1/3), five teachers, social worker, 3 instructional aides; transportation costs, a supply budget ($3,000), a percentage of indirect costs such as heat and light.

STUDENT PROFILE

Listed below is a profile of the students served in the program to give an understanding of the type of students the program was designed for and has served. We have serviced 53 to date:

1. Ages at time of entrance to program
   11 years— 3
   12 years— 8
   13 years— 9
   14 years—12
   15 years—19
   16 years— 1
   17 years— 1
2. Race:
   Black—29
   White—22
   Latino— 2
3. Sex:
   Male—47
   Female— 6
4. Medication prescribed to control behavior: 16
5. Receiving support services from Pontiac Youth Assistance (A counseling program for first offenders on minor community complaints): 2
6. Juvenile Court Involvement: 21
7. Residential placement at the Children's Village Juvenile Detention Facility within the past two years: 14
8. Receiving individual therapy from an outside private clinic: 12
9. Previously or currently admitted to residential treatment facility: 14
10. Presenting problem at time of referral to program:
    a. Disruptive behavior in school over an extended period of time.
    b. Aggressive and hostile behavior toward peers and adults at school.
    c. Episodes of explosive behavior and tantrums.
    d. Severe learning deficits.
    e. School truancy.
    f. Delinquent behavior in the community.
    g. Disruptive home environment.
    h. Character disorders.
    i. Organic brain dysfunction.
    j. Repeated periods of academic failure in school.

Curriculum

Keeping in mind that Bailey School is not a day treatment center, but an educational program for adolescents with severe emotional problems who could not be appropriately placed in any other school program, the curriculum has been developed in the following areas:

1. Mathematics, Reading and Language Arts—40% of the day.
2. Social Studies and Career Education—20% of the day.
3. Physical Education—20% of the day.
4. Pre-vocational—20% of the day.

MATHEMATICS

The majority of the students in the program function below grade level by three to four years. The goals of the program in mathematics are:

1. Basic Processes: To enable each student to master the basic math processes of addition, subtraction, multiplication and division.
2. Basic Living Skills: To enable each student to master skills in the following areas:
   a. Time (including days, weeks, months, seasons, as well as using clocks).
   b. Money (including money values, making change, use of a bank for checking, saving, how to pay bills, plan a budget).
   Measurement (including linear, liquid, weight and temperature).

LANGUAGE ARTS AND READING

Due to the severe deficits of the students in reading the goal of the program is to enable each student to develop basic reading survival skills. These skills include:

1. Development of a basic sight vocabulary based on the functional core list of words received from Oakland Schools.
2. Development of the ability to use reading skills in the community including such skills as using newspaper ads as a source of shopping and seeking jobs, use of reference tools such as a telephone directory, road maps, dictionary, traffic and road signs
3. Development of communication skills, both oral and written including such skills as:
   a. The ability to express ideas in a logical, sequential way.
   b. The ability to write in a neat and legible manner.
   c. The ability to spell and write words in his basic sight vocabulary so that the student can use the words to express himself in writing.
   d. The ability to fill out forms, such as applications for employment, driver's license, social security card.

SOCIAL STUDIES AND CAREER EDUCATION

Goals of the curriculum include:

1. Expanding the student's knowledge of his community and its resources.
2. Exposing students to various career opportunities within the community that are realistically obtainable.

This curriculum is taught through three week mini courses which included this year:

1. Communication: The study of a local newspaper, television station, radio station, including a field trip to each.
2. Jobs in the city which explored various jobs in the city, including field trips to a hospital and automobile factory.
3. Ecology and conservation of natural resources.
4. Ethnic culture studies, including Black, Latino and Oriental
5. Mapping, how to find one's way around the city.
6. Science
7. City government and its structure.
8. Drama

PHYSICAL EDUCATION

The goals of physical education are:

1. To provide an opportunity for the student to release his energy and aggression in appropriate ways through physical activity.
2. To introduce the students to lifetime leisure sports such as bowling, tennis and swimming. An extensive swimming program has been developed with Oakland University. Also, one day a week, the students make use of the Howard Dell Community Center for playing pool, ping pong and basketball.
3. The development of the student's fine and gross motor skills which is a deficit for many of them.

PREVOCATIONAL

The goals of this area are:

1. To enable each student to acquire the necessary skills for entry into a vocational program.
2. To enable the student through individual and group projects to develop a feeling of pride and accomplishment within themselves.

The curriculum was taught through three week mini courses which included:

1. Woodshop
2. Arts and Crafts
3. Home Economics
4. Leather Crafts
5. Handicrafts

When students are 15 or 16 they become eligible for enrolling at the Vocational Center in Pontiac for half a day. If they have shown good behavioral controls and are able to work independently, they are able to choose a vocational course at the Center and continue part day at Bailey School.

SOCIAL-EMOTIONAL

As with academics, individual goals are developed for each student in the social-emotional area. The overall goal for all students is to enable each of them to develop the inner controls necessary so that the student can manage his own behavior appropriately. The program operates on the assumption that each individual is capable of and responsible for managing his own behavior, and that each behavior by an individual has its consequences, which may be positive or negative depending on the situation and the choices the individual makes.

The social-emotional goals are accomplished through a variety of techniques which include:

1. A behavior modification system, which enables the students to earn rewards and privileges when his behavior is appropriate and a loss of rewards and privileges when it is not appropriate.
2. Individual and group therapy with the social worker.
3. Individual counseling by the teachers.

4. Weekly staffing on students with very difficult behavior to develop consistency in management.
5. A firm, structured, yet warm approach by the staff.
6. Frequent contact and conferences with the parent and student.
7. Close cooperation with outside supportive agencies.

Cooperative Programming for Behavior Disordered Students: A Model Program

Charles McCormick, Ed.D
and
Mark L. Becker, ASCW

Introduction

The Northwestern Illinois Association (NIA) is a regional joint agreement that was formed by 80 school districts. It includes 10 counties, 5,800 square miles and approximately 200,000 school aged children. In the delivery of services, NIA often deals with local joint agreements rather than districts. This is especially the case with small districts which are more likely to band together in a local joint agreement for the provision of special education services.

NIA serves three primary purposes:

1. Supportive services for low-incidence programs.
2. Special supportive services not available at the local level
3. Administration of federal funds and projects in the region.

Within these areas NIA provides several types of services to behavior disordered students and programs. These include:

1. Diagnostic consultation
2. Program development consultation
3. Inservice training
4. Media center and materials depository
5. Project Advocate

The services NIA offers are intended to be supportive to those services which districts and local joint agreements provide. These would be services that can not be afforded locally or for which there are too few children in a district or joint agreement to warrant the provision of a service. Hopefully, these efforts increase the comprehensiveness of the services available to behavior disordered students.

Diagnostic consultation involves:

a. Scheduling pediatric and psychiatric consultants to evaluate children in local districts.
b. Screening and scheduling referrals for the pediatric and psychiatric consultants.
c. Coordinating referrals to special medical services that result from the pediatric and psychiatric evaluations.
d. Coordinating referrals from within the region to major medical centers and clinics.
e. Providing consultation to local staff to assist in implementing recommendations resulting from the diagnostic services above.

Program development consultation is an attempt to assist local staff in developing high quality local programs for behavior disordered students.

The region provides inservice training in specialized areas (e.g., consultation skills) as a support to local staff.

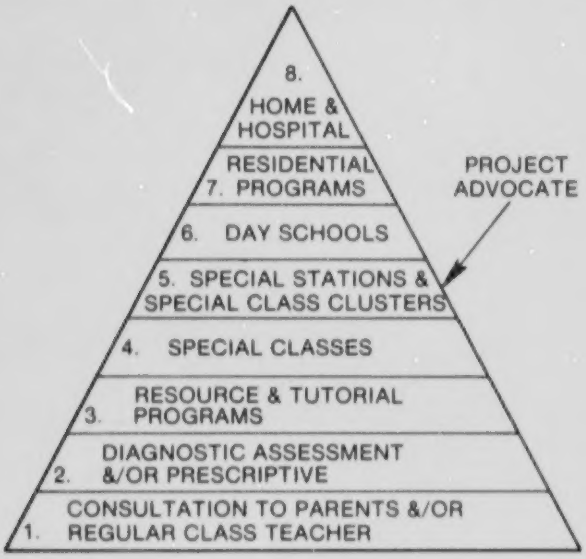
The media center and materials depository (REMIS) allows NIA to provide access for local programs to materials and services (e.g., diagnostic video taping) that are too costly or used too infrequently for the local district to develop or purchase.

Project Advocate is a program for the severely behavior disordered which NIA provides to a subregional area within the ten county region. It gives a student a last public school option after the local intensive behavior disorder program has been unsuccessful with a student.

Project Advocate serves a two county subregion within the ten county region. We attempt to make the program available only to behavior disordered children who are considered severe. Arbitrarily we estimate that there are between 75 and 80 children whom our program would serve from the 20 school districts in these two counties. (ADA in 20 Districts = 78,200 USOE B.D. Incidence Rate = 1% = 782; "Severe" = 1/10 of 1% = 78)

The continuum of services model represents a sequence of services from the least restrictive to the most restrictive educational alternatives. Within this model Project Advocate belongs in section 5. The project's basic goal is to prevent students from being extruded to levels 6, 7, & 8 which are totally outside of the public schools and to reintegrate them into less restrictive options 4, 3, 2, & 1. This program is discussed in detail below. (see figure 1, below)

FIGURE 1. Special Education Continuum of Services Model



The Cooperative Approach to Programming

Educational Services can be planned and delivered via organizational structures that reflect the incidence rates of educational disabilities in children.

FIGURE 2. Services Delivered by Administrative Structures

Administrative Structure	Type of Service Provided
Local District	Regular Education
Multiple District/Joint Agreement	High Incidence Special Education
Multiple Joint Agreement Regional	Low Incidence Special Education

However, it can be very difficult to develop plans to serve behavior disordered students that correspond with these three levels of services. Such plans, however, can make the continuum of services approach work smoothly as a multi-layered system rather than a hodgepodge of poorly interrelated subsystems. Such planning requires the resolution of philosophical issues (e.g., Should children be removed from regular education settings to receive special education services) and of organizational issues (e.g., Should regions offer basic education—classrooms, teachers, aides—or merely services in support of basic education?) Clearly the systems approach implied by the thrust of P.L. 94-142 compels us to plan and cooperate in our delivery of services to these children. PA is a product of such planning and cooperation.

Twenty school districts have agreed on the need for PA and have requested that the region develop and administer it.

This kind of cooperative programming has both interesting problems as well as attractive advantages. The major advantages derive from the population base available through cooperative programming. In a cooperative approach administrators will be presented with enough low incidence children to warrant establishing programs and utilizing supportive personnel. In many instances this is the most efficient use of resources since it allows for the distribution of costs across several districts.

A more subtle advantage derived from the larger population base concerns the classroom populations. The larger the population to be served, the smaller the ranges of chronological ages, academic abilities and other student needs one will find in a given classroom. For example, if a single district attempted to operate a class for severe behavior disordered, one might find in that classroom 8 or 10 students ranging from 6-11 years in age and from Kindergarten to grade 8 in reading performance. A range that wide in chronological age and academic performance creates a great deal of stress for the teacher especially if supervisory and supportive personnel are not readily available. Although we have not located findings to support this idea, decreasing the age range and range of academic abilities of students in a room may also lead to more effective learning.

Another advantage of cooperative programming is that concern can be voiced by the cooperative districts to a district which is offering services or programs that are less than adequate. Districts want to be sure that there is not excessive dependency on or inappropriate use of, the cooperative program. They do not want a local district to use the cooperative program as an option that allows it to do less than it should at the local level for its handicapped children.

Our experience in cooperative programming has made us aware of several problems and issues. A major problem is that of coping with the differences between the districts. Each district expects to receive its fair share of services or resources. However, districts differ as to their sizes, staffs, basic philosophies, needs, student population, proximity to the project and their philosophy regarding the program. Such factors must be dealt with in attempting to establish an equalization of services.

Districts that are closer to the project have a disproportionately large number of students in the program. This may be a result of the lower cost of transportation and the ease in scheduling transportation as compared to districts that are farther removed from the project. Furthermore, some local staffs believe that these districts also have better communications with project staff and are more successful at complying with the referral procedures.

Districts and buildings within districts differ as to their tolerance of, and as the skills their staffs can bring to bear on, deviant behavior. Thus, students need to be trained to different criteria levels prior to reintegration into various local programs.

Tensions and frustrations that are felt in the local districts eventually will effect the project. For example, if morale in a district is low, teachers who are about to receive reintegrated students may resist making the extra efforts these students may need especially in the areas of behavior control and individualized academic prescription.

There can be a certain amount of tension between the substantive nature of the program and the local needs of the districts. For example, the PA staff is behaviorally oriented and requires data about the student's behavior prior to placement in the project. This data usually requires a special effort by local staff to obtain. This is sometimes resisted. Also, since PA is a program serving several districts we feel some obligation to insure that students placed there are truly in need of the program. We established criteria and procedures that attempt to assure this fact. However, these criteria and procedures may place us in conflict to assure this fact. However, these criteria and procedures may place us in conflict with a local district who wants to staff a child into the program immediately or who wants to inappropriately place a child in the program.

Control is another problem area of which we have become aware. It is a necessity in cooperative programming that one be clear about what he/she can and cannot control. Our staff has a great deal of control over the substantive aspects of the PA program. Beyond that we have control over what we say to the staffs in our referring districts and how we say it. Our interpersonal and professional relationships with those people are essential tools in advocating for our students. We do not have control over the attempts that are made to work with the student or his parents prior to referral to our program. We assume that the district referring a student to this program will insure that due process is followed. At times it is not and we are in a bind. We do not control the attempts that are made to work with the students who are reintegrated into a local program. Our consultation may or may not be utilized. Ultimately, we do not have control over how long a student stays in the program. A few students have been pulled out of the program prematurely. Another area in which we have no control over is that of the in-district calendar. School district calendars in Illinois are set by the local district. Thus, student attendance and transportation patterns will differ among the referring districts causing some confusion. The calendars can also be an obstacle to training efforts during the school year. Finally, the project staff finds that it is difficult, if not impossible, to control the behavior of students on school buses. Students who attend a cooperative program that serves a relatively large geographical area can be on the bus for up to an hour. For behavior disordered students this situation can elicit problem behaviors which staff, parents and bus drivers are hard pressed to control. Overall, control is a basic issue to be confronted in cooperative programming since the act of cooperating will produce a loss of autonomy for local staff, staff in the cooperative program and parents.

Identifying The Behavior Disordered Student

Those attempting to deal with behavior/emotional disabilities often try to classify people perceived as deviant into categories. However, the identification and designation of deviant behavior is as much a function of the perceiver as they are of the behavior (Newbrough, 1972). In a classic cross cultural study (1934) Benedict noted that certain types of people considered "sick" and "abnormal" in the United States fitted readily into other cultures. Most ecological psychologists believe that it is not yet possible to delineate classification systems, since, by definition, such activity limits the field of study and does not take into account the ecological system with its myriad of interactions. Disciples of the reinforcement theory strongly oppose such schemes since they believe that every child is unique and that grouping is neither necessary or desirable. Classifications of deviants is often done without their knowledge or consent and the classification label can profoundly and in some instances deleteriously affect their lives. Nevertheless, reality compels educators to do some grouping for the delivery of services (Research Associates, 1976)

Problems related to the definition of behavior disorder are encountered in the process of developing programs to serve students classified in this manner. It relates especially to the identification and diagnostic processes which are major components of the programs.

We have considered at least five different approaches to the intake process in the developing programs for the behavior disordered. These are:

1. Strict Criteria Method
2. Flexible Quota Method
3. Fixed Quota Method
4. Filtering System
5. Intake by Committee—Multiple Criteria

A. *Strict Criteria Method:* In this approach a student is deemed eligible for the program if he manifests certain behavioral characteristics. For example, of a checklist of 15 problem behaviors students must engage in 5 of these behaviors at a frequency of no less than 3 times per day per behavior. The criteria for eligibility are objective and measurable.

B. *Flexible Quota Method:* With this method each referring district is assigned a quota of placements in the B.D. program depending on its student population. This quota determines the number of slots available to each district at the outset of the school year, and eligibility and placement become in-district decisions. After a certain date (e.g., October 15) the quotas are dropped and the remaining spaces are filled on an open referral basis. This puts some pressure on the referring parties to examine each referral carefully and establish priorities.

C. *Fixed Quota:* This approach differs from (b) in that each districts quota is held for it throughout the school year. Each district is billed the entire year for its quota of spaces regardless of when or whether they are filled.

D. *Filtering System:* On the filtering system the B.D. student, as (s)he is defined for each level in the continuum of services, is identified as a result of a progressive series of successes or failures. Basically, a student is eligible for a more restrictive placement if he posses certain characteristics and has exhausted all service/placement options in all less restrictive settings. (see fig. 3 below)

E. *Intake by Committee:* This is a method currently in use in the public schools in Rockford, Illinois. Intake by committee is somewhat similar to buying a house. One establishes criteria and standards relevant to several different areas (e.g., social, academic, behavioral, physical), but there is only one decision to be made regarding placement in the program—Yes or No. In the Rockford Public Schools that committee is composed primarily of building principals, and special education personnel. They are interested in assuring that services are available to students in their own buildings when they are needed. Thus, they carefully screen referrals to insure that spaces in the program are not taken up by inappropriate placements. The committee has options available to it other than placement in a B.D. program and uses them to implement a filtering system model (See "D" above). (For more information about this method please contact BD/LD Supervisor, Muldoon Center, 121 S. Stanley, Rockford, Illinois 61102).

Discussion has focused on the geographical and administrative contexts around PA which are important determinants of the nature of a cooperative program and on the problem of defining who the behavior disordered student is. At this point our responses to some of these problems will be identified through a discussion of the nature, procedures and focus of the project itself.

Project Advocate is a short term (2-3 semester) self-contained program for 50 students who exhibit behavior disorders. The age range is 6 to 16 years. There are, at present, six classrooms: 1. primary-behavioral/communication disordered (ages 5-7); 2. primary (ages 6-9); 3. intermediate (ages 10-12); 4. intermediate (ages 10-12); 5. Jr. High (ages 13-14); 6. High School (ages 15-16). The Jr. high/high school classrooms are combined and "team taught." Each classroom has a certified teacher and a full time aide.

Student Selection

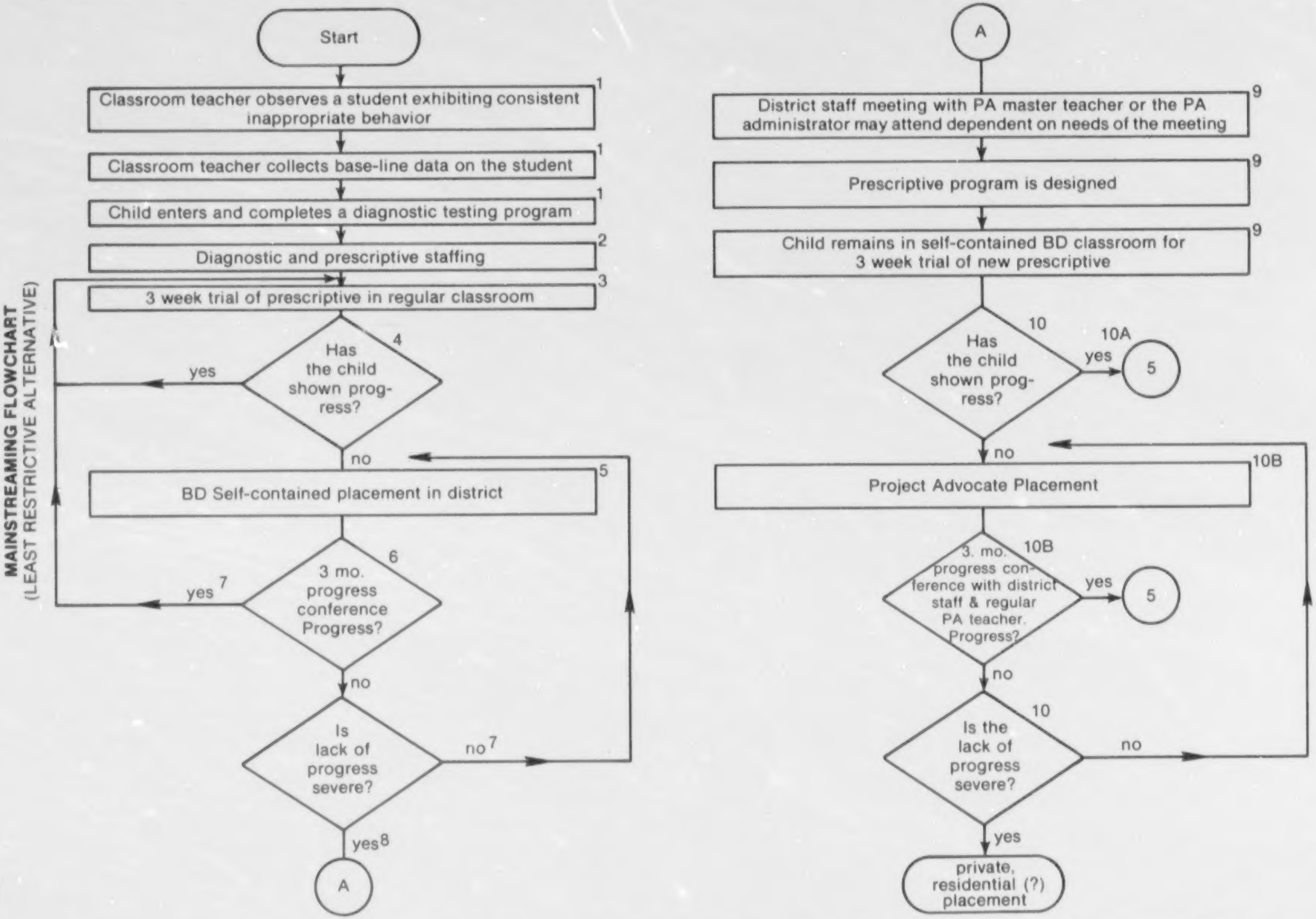
Students are usually referred to Project Advocate because they frequently engage in one or more low intensity behaviors (i.e., non-compliance in completing assignments or following school rules, swearing, talking back, roaming the room or the halls, pestering other students, making inappropriate or loud noises) and/or occasionally engage in high intensity behaviors (i.e., being physically abusive toward others, self mutilation, destroying property, stealing).

Often, the student has had "difficulty in school" for one to four years prior to referral to the project. In those districts that have self contained classes, either B.D. or L.D., the referred student has usually participated in that more specialized environment . . . . without success. Special education personnel who make referrals to Project Advocate, feel that the student could profit from a highly structured classroom situation.

When a student is referred to Project Advocate a referral "package" is sent to the referring school. This package contains the Project Advocate Referral Checklist of sixteen global behaviors, data sheets on which to record a three to five day baseline of three priority behaviors and a request for a recent psycho-educational evaluation.

Following a classroom observation, the Diagnostic Consultant Teacher (DCT) informs the district personnel whether the student is eligible for acceptance into the program. This determination is based on a judgement on the probability of the current classroom teacher being able to modify the students behavior with the support of Project Advocate consultation and on the frequency and intensity of the student's behaviors. The final determinant of placement is how well the student will fit into the appropriate Project Advocate classroom. If the student is eligible but Project Advocate has a waiting list, consultative services are offered. If the student is not accepted, a one-time prescriptive intervention plan is developed and sent to the teacher and support personnel.

FIGURE 3. Filtering System For Intake: An Example


MAINSTREAMING FLOWCHART
(LEAST RESTRICTIVE ALTERNATIVE)
Start
Classroom teacher observes a student exhibiting consistent inappropriate behavior 1
Classroom teacher collects base-line data on the student 1
Child enters and completes a diagnostic testing program 1
Diagnostic and prescriptive staffing 2
3 week trial of prescriptive in regular classroom 3
Has the child shown progress? 4
yes
no
BD Self-contained placement in district 5
3 mo. progress conference Progress? 6
yes 7
no
Is lack of progress severe?
no 7
yes 8
A
A
District staff meeting with PA master teacher or the PA administrator may attend dependent on needs of the meeting 9
Prescriptive program is designed 9
Child remains in self-contained BD classroom for 3 week trial of new prescriptive 9
Has the child shown progress? 10
10A
yes
5
no
Project Advocate Placement 10B
3. mo. progress conference with district staff & regular PA teacher. Progress? 10B
yes
5
no
Is the lack of progress severe? 10
no
yes
private, residential (?) placement

It is only when the referral process (i.e., social/behavioral history, parent conference, and staffing with parent and special education cooperative) has been completed that students are accepted into the program (contingently upon a vacancy in the classroom). The student is placed on the waiting list if there are no vacancies.

At the parent conference all aspects of the program are explained, including the following points:

1. The program uses positive reinforcement. Students will be rewarded for complying with staff requests, making better decision (such as ignoring peers' teasing), following class rules and completing assignments. Parents will be called weekly if the students have had a "good" week. For many parents, this would be the first time in years the school has called to provide them with positive feedback about their child.
2. If the student does not complete assignments in the morning, lunch may be delayed up to an hour. The student may remain until 5 p.m. if all work during the day is not completed. (Usually dismissal is at 2:30 p.m.)
3. Tokens, credit card and contract behavioral levels, and the privileges associated with each level, are explained. These levels are a major method of evaluating student progress in the program.
4. Quiet training procedures are explained and demonstrated. The time-out room and the time-out log are shown to the parent. When staff must assist students in going to the chair, mat, or time-out room, the methods by which they are to hold (or restrain) the student in order to minimize the possibility of the student injuring himself or staff are specified. Whenever possible clothing is used as a hand hold rather than applying pressure to a student's hand or arm. The parents are informed that the Project does not assume responsibility for torn or ripped clothing.
5. Parents must sign the Project Advocate contract which specifies that they are cognizant of the behaviors which have resulted in their childs' referral and are aware of procedures which will be used to change these behaviors.

In summary the intake process for Project Advocate is a blend of the "Strict Criteria Method" and the "Filtering System". Checklists, psych-educational evaluations and on site observation are used to help determine the appropriateness of the referral. Procedures used to help change student behavior, (primarily positive reinforcement) are explained to the parents. Implications of the "demand-compliance" model are also explained so that the parents are aware of the use of graduated guidance, restitution, over correction, and quiet training.

Basic Intervention Model

Project Advocate provides a consistent, data-based, contractual, intensive learning environment for students. Individualized prescriptive programs are developed to increase appropriate academic, social and decision making skills. Consequences are provided for all decisions students make. Techniques and procedures utilized in changing students behavior are a blend of experimental applied behavioral analysis and broad spectrum behavior therapy.

The student population in Project Advocate does not consist of hard core delinquents, psychotic or autistic youth. Although the students are at times violent, it is primarily their frequency of non compliance which exceeds the capabilities of public school personnel. Approximately 20% of the students are living with a single parent. There is a multiracial mix of students in the project, with 67% Caucasion, 22% Black and 11% Latino.

There are three basic behavioral levels that students must achieve and maintain for three weeks each (See Figure 4). These levels are: (1) tokens; (2) credit card; and (3) individual contingency contract. Each level has within it steps for more responsibility, more privileges,

FIGURE 4. PA Intervention Model

A. Contract between Project Advocate and referring school: Signed by student, parent, referring school, Project Advocate
B. Behavioral Levels within Project Advocate
    1. Tokens
    2. Credit Card
    3. Contract
C. Response Cost System
    1. Fines
    2. Restriction
    3. Quiet Training:
        a. 5 minutes chair
        b. 10 minutes mat
        c. 15 minutes time out room
D. Students work completed—80% correct or:
    1. Remains after school
    2. Homework completed prior to admittance next day (parents notified)
E. Reintegration back to referring school
    1. Staffing
    2. On site observation
    3. Consultation
    4. Student reintegrates from 1-1/2 hr. to 1/2 day
    5. Slot for student remains "open" in project for 20 school days contingent on:
        a. Project Advocate notified within 24 hours of any "incidents" i.e., not completing assignments; fighting
        b. Home school continues to track data for four weeks and calls Project Advocate to provide feedback weekly.

and less teacher monitoring. After a student has maintained the highest status on level 3 for three weeks, the referring district (LEA) is notified, and a re-integration staffing is set up within 10 school days.

When students enter the program, the three levels are explained to them. In addition, the specific behaviors that would result in a response cost (i.e., a fine) are indicated (and are posted in each classroom) and the three levels of Quiet Training (Q.T.) are explained and demonstrated. Quiet training, as used in the project, has three components: sitting on a chair for 5 minutes; lying on a mat for 10 minutes; staying in a time out room for 15 minutes.

Quiet training procedures require careful monitoring and documentation to insure student rights and to protect the program from adverse public reactions to these procedures. The following are essential for the proper use of these procedures. They should be consistently administered contingently upon occurrances of previously identified undesirable behaviors. They should be brief procedures, 1-15 minutes, with a maximum predetermined time limit, e.g., 90 minutes in Project Advocate. There should be a system for recording information including the student behavior exhibited, the signature of the staff member implementing the procedure, time started-time stopped and the duration of the procedure. There should be an objective assessment of whether or not time-out is fruitful in remediating the problem behaviors. Project Advocate also urges programs to formulate a written statement of procedures to be followed by staff whenever using a quiet training procedure (i.e., chair, mat or time-out room) which explains what to say to the child and how to say it and how to physically move the child if necessary. (An explanation of Project Advocate's quiet training procedures is available on request.)

Students are given the opportunity to take their own time out after receiving the instruction from the staff. If they fail to respond to the instruction within 5 seconds, graduated guidance is used to physically move the student to the time out area. Two staff members usually assist a student to the area. Staff were trained in restraint and movement procedures in a 30 hour inservice at the beginning of the school year.

There is a focus in the program on students completing their tasks during the time allocated, with 80% accuracy. Students who do not complete their work remain until 5 p.m. Students who are bused over 10 miles usually are not kept after school. Their work is sent home with them and when they return the following morning the work must have been completed. Parents are notified of this procedure. If the work is still not completed, the student will be placed on restriction the following day until both days work are completed.

"Restriction" means that a student cannot engage in any of the activities of privileges, cannot earn tokens, or participate in any school event that is reinforcing. Students who refuse to pay their fines will have their fines doubled, and if not paid, then the student is on restriction until the fine is paid.

In addition to the academic and behavioral aspects the project also offered activities in affective education. Twice a week for 20-45 minutes, all students participated in groups characterized by a value-clarification/decision making orientation.

Counseling is also offered at the project. The parent-student counselor meets with students individually and in small groups as well as with parents interested in the acquisition of child management skills. There has been minimal request for the services of the counselor by the parents.

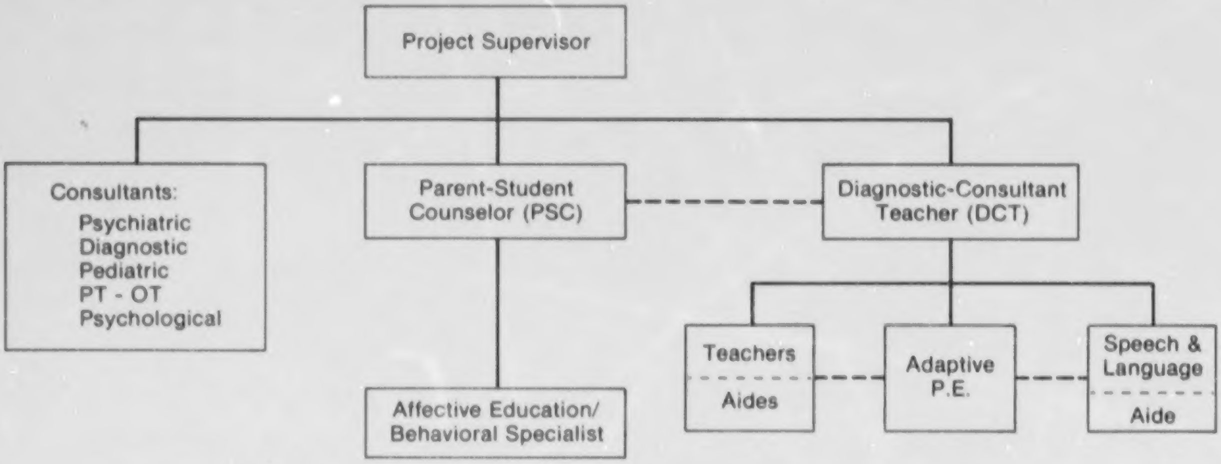
Project Advocate proposes to expand the counseling services for the following year and focus more intensely on parental involvement. As a public, special education program, parental cooperation cannot be mandated.

Administrative Staff Requirements

Ideally, a behavioral program should be able to run at a high level of consistency independent of any given personality if indeed the staff within the program have been trained in the specific skills necessary to maintain the program. However, the "basic" behavioral skills do not take into consideration many other skills that are necessary to the success of a program . . . how staff communicate to each other i.e., interpersonal skills; assertive skills; how staff perceive administrative support; availability of support to "help out" in times of crises (for example, when two adolescent males engage in a fight and when staff start to intercede, one or two other males in the class get out of their seat and tell you to "let them handle it themselves.") Project Advocate has built in an administrative structure (personnel) that is intended to provide support to the staff. The supervisor of the project must have a MA degree in education, psychology, social work or related field and four years experience in mental health and/or education. Prior experience in working with behaviorally disturbed children and their families; consultation to public schools; prior experience in program and staff development are also required and a behavioral orientation is necessary.

The project supervisor relates directly to NIA and to the special education directors who refer students from their cooperatives. The supervisor is responsible, on an overall basis, for the academic and social-behavioral progress of the students. He is also responsible for formulating the annual budget, however the billing, writing of the Title I grant, and seeking approval for the reimbursement of extraordinary cost is the responsibility of NIA. Within the project, the two key supportive personnel positions, besides that of the supervisor, are those of the Diagnostic-Consultant Teacher (DCT) and the Parent-Student Counselor (PSC).

FIGURE 5. PA Organizational Chart



The DCT position requires a minimum of MA degree in education and two years teaching experience. A Special Education Teacher Certificate in the areas of Behavior Disorders and Learning Disabilities is required. The DCT assists the instructional staff in the development and implementation of educational prescriptives and objectives. The DCT also monitors the implementation of these prescriptives and provides diagnostic testing as needed. The DCT processes all new student referrals including observing the referred student in his current (pre-referral) setting.

The Parent-Student Counselor (PSC) position requires a minimum of a MA in education, psychology, social work or other related field and two years experience providing therapeutic service to children (ages 5-16) and their families. Prior experience in therapy groups with both students and parents is necessary as is a behavioral orientation. The PSC develops a written plan for the affective/behavioral components of the project curriculum in cooperation with the Supervisor and the DCT. He also develops and implements a parent training program and therapeutic programs for each child in the project.

These three positions, Supervisor, Diagnostic Consultant Teacher and Parent Student Counselor, are the main administrative positions within Project Advocate. Many decisions are made within a consensual model of decision making with these three individuals. Not only must these three individuals have an expertise within their own field, but they function as consultants to staff within and without the Project. In addition, they should be assertive and be able to provide feedback to each other and to the project staff in a nonthreatening way. In other words, interpersonal skills must be at an optimal level.

The professional teaching staff in the Project must have a minimum of a BA degree and hold certification within the state in Behavioral Disorders or Learning Disabilities. Of the six classroom teachers, four hold masters degrees as well. Perspective teachers are selected primarily upon their style and performance during their interview. They are requested to bring examples of diagnostic work ups and prescriptive plans which resulted. Responses to "what would you do if" situations are evaluated, as are interpersonal and assertive skills. The decision to hire or not hire the individual is based upon multiple criteria.

The professional teaching staff and the aides have a high "burn out" rate. The turnover for the professional staff has been approximately 50-75% for the past two years. Turnover for the aides has been higher. The high aide turnover rate may be a function of the low pay they receive ($4,000-5,500) and the long hours (8:30-4:00) with few breaks. The teachers' salaries are established by the salary schedule of the Projects' administrative district. Carrying out prescriptive behavioral programming is often an aversive, fatiguing process. All six teachers are under 30 years old and the aides are predominantly in their mid-20's. The youthfulness of the staff contributes to their flexibility and ability to "revive" after some of those "bad" days. Due to the high turnover of staff, an effort has been made to specify the minimum behavioral skills needed to produce consistency within the program. This allows any teacher to provide consequences for any student regardless of "who the student belongs to." At this time, the Project is attempting to develop an individualized training/inservice program to facilitate and ease the administrative burden involved in training and supervising new staff. Training can be especially burdensome when it is for new staff who are hired during the school year.

There are three concepts that contribute to the uniqueness of Project Advocate: it is contractual; it is consistent; and it is data based. The *contractual* element of the program occurs when a student is accepted into the program. At that time, the Special Education Director, or a representative signs a contract wherein problem behaviors are specified in the Project Advocate referral checklist. In this contract the project agrees to reduce these target (or problem) behaviors by a factor of 90% of baseline or to a frequency of 1-2 per month. Behaviors such as physical aggression to adults or peers, stealing and destruction of property will be reduced to a frequency of "0" per month for at least two months prior to attempting to reintegrate the student. In addition, the students shall complete at least 80% of their academic work at a criteria level of 80% or more correct responses.

The second concept area is the *consistency* within the program. There is a competency list of behavioral treatment skills that the staff (teachers and aides) have performed to criteria during their training. This list includes such skills as bland affect, response costing, required relaxation, and giving verbal and nonverbal reinforcement. It is assumed that the staff has no behavioral skills at the onset. The inservice at the beginning of the '76-77 school year was a 30 hour program that consisted of didactic lectures, modeling and role playing. This consistency is closely related to both the staff training and the referral behavior check list. The Project specified how staff are to respond to each of 16 global behaviors. Thus, a student who exhibits a referral behavior should receive the same basic response from any project staff member. Staff are monitored intermittantly and provided with feedback on the treatment skills which were taught to them in the inservice program. This is an integral part of the teacher evaluations which occur at the close of each semester.

The third concept is the *data-based orientation* of the program. Staff members are observed and evaluated on their behavioral skills and required to fill out data sheets on all 50 students. These sheets include the subject area covered, the successful completion of that assignment, and how the student chooses to spend his tokens, i.e., for consumables or nonconsumables (e.g., activities). This data is keypunched and the project receives a monthly summary for each student and for each class. These summary reports include the monthly frequency of the occurrence of each of the 16 global target behaviors and the number of academic tasks the student completed with 80% accuracy.

Development time for the students data sheet, the computer program, and "turn around time" to receive useful data summaries is about 3 months initially. At present, the "print out" summaries are returned to Project Advocate 10-15 work days after the end of the month.

For those students who seem to have "plateaued" the monthly data and independent classroom observations enable staff to make a conscious decision about progress and help pinpoint what is impeding progress.

The fact that the program is contractual; consistent; and data based contributes to the objective evaluation of student progress and staff accountability.

Physical Space

The utilization of physical space has programmatic implications for both teaching and support staff. The classrooms are divided into functional areas according to the behavioral levels of the students, i.e., students who are on the token level are seated apart from those who have achieved the credit card or contract level. The quiet training chair and mat are placed in the corners of the room. Each classroom has a rug in an area where students can spend their earned "free time". Since graduate guidance may be required at any time with a student, sufficient space must be allowed in the seating arrangements of students for two staff members to "bracket", or get on both sides of, the student. Sufficient space must also be available for staff to have a desk, file, storage cabinet, and bookshelves for resource and students materials.

Support staff need the physical space in their offices to carry out their responsibilities. The diagnostic-consultant teacher needs room to test individual students and confer with the teaching staff. With a focus on therapy, the counselor needs room to see 2-3 students or a family. Since the supervisor frequently provides an orientation session for parents on their initial visit to the project, consults with staff and has contact with special education directors a larger office is required. Speech and language clinician and aide both require office space large enough to house tables for primary students as well as adolescents.

In addition to the above, two additional classrooms are utilized. A multi-purpose room is used for conferences, inservice, student staffings, and as a teacher lounge/resource room. The second classroom is an "activity room" which has two pool tables in it. This is particularly reinforcing for the adolescents who can "earn" time to go to this room.

Project Advocate does not share the building with other public schools. During the '76-77 school year, the Project paid $250/mo/classroom for 8 classrooms and an office area. Utilities (except phone and custodial services) were included in the rent.

Funding

PA is a costly program. However, a combination of federal, state and local funds allows us to offer the program to students at a net cost of zero dollars to the districts. Please refer to Figure 6 as you read. In the discussion that follows assume that there are 60 students in PA, that the total program cost is approximately $330,000 and that, therefore, the per capita cost is $5,500.00.

The average per capita in district cost to educate a student in the 20 districts that send students to PA is approximately $1,500.00. These districts have to expend this money on their students regardless of where they are educated. This generates $90,000 for the program and reduces the net per capita cost from $5,500.00 to $4,000.00

The State of Illinois funds special education via reimbursement for personnel. PA receives $6,250.00 for each of eleven professional staff and $2,500.00 for each of 11 nonprofessional staff. This generates $96,520 which is rebated to the districts at a rate of about $1,605 per student reducing their per net capital cost from $4000.00 to $2,395,84.

The studetns at PA were approved for Title I funding which provides about $30,000 or $500 per student. This reduces the net per capita cost to the district to $1,895,84.

The State of Illinois also provides reimbursement of up to $2,000.00 per child for extraordinary costly educational programs. PA is approved for this kind of funding which yields approximately $113,000 or about one third of our costs. This provides approximately $1,900.00 per student which reduces the net per capita cost to zero.

Conclusion

Project Advocate is an exemplary program for low unacceptable within the mainstream of traditional education. This cooperative program was implemented in a subregion under the auspices of Northwestern Illinois Association (N.I.A.). The integration of a "demand-compliance" model and behavioral programming necessitates a staffing pattern and administrative expertise that enables this short term program to serve as an additional resource to all of the school districts within Kane and DeKalb counties. Financially, school districts would find it difficult to run this program as a local as opposed to regional service. Local districts do not expend any administrative cost in time or money for this program. The billing, writing of the Title I grant, and seeking approval for the reimbursement of extraordinary cost is the responsibility of NIA. Since Project Advocate is an autonomous, self-contained project, behavioral procedures can be utilized and demands on staff made that could not be done if Project Advocate were sharing quarters with regular public educational program.

Cooperative programming is not a new approach in special education. However, for behavior disordered students that cooperative approach to service delivery presents unique problems and advantages.

The productivity and success of Project Advocate support the cooperative approach and demonstrates that it can be an effective mode of service delivery for behavior disordered students at a cost that is equal to or less than the in-district per capita cost to educate a child.

References

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FIGURE 6. Budgetary Data

Assume there are 60 students in the program and that the cost per student is approximately $5,500.00. Each district is charged $5,500.00 for each student it has in the program.

PROGRAM FUNDING PATTERN			CUMULATIVE PER CAPITA NET COST TO DISTRICT
	PROGRAM	PER CAPITA FUNDING	
			$5,500.00
In-district cost to educate a child	90,000 ÷ 60	1,500.00	4,000.00
State reimbursement for special education staff (11 professionals × 6,250 plus 11 non-professionals × 2,500)	96,250 ÷ 60	1,604.16	2,395.84
Title I funding for 60 students	30,000 ÷ 60	500.00	1,895.84
Excessive costing funding from IOE	113,750.40 ÷ 60	1,895.84	—0—
TOTAL	330,000.40	5,500.00	

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Child Abuse and Neglect: An Educational Concern

Mary McCaffrey, Ed.D

Introduction

During the past three years considerable public attention has been brought to the plight of abused and neglected children. Acting on behalf of these children, the Congress in 1977 passed The Child Abuse Prevention Act, (Public Law 93-247) which provided technical financial assistance to develop and implement programs relating to the prevention, identification and treatment of child abuse and neglect. At the present time every state and the District of Columbia requires the reporting of non accidental injury to children. Most states specify the reporting of neglect as well. More than half include sexual abuse and emotional or mental injury in their definition of abuse and neglect. Furthermore, at least 37 states specifically mandate that educational personnel *must* report suspected cases of child abuse and neglect to the proper authorities. This legal responsibility raises certain administrative concerns as it places an increased responsibility on school personnel. Considerable effort is needed to train teachers and administrators on the identification of abuse and neglect, develop reporting procedures and work closely with community agencies. Fortunately, many administrators recognize the way in which parental or institutional abuse impacts on children under their care and are assuming a more responsive role.

For those administrators and teachers who work with exceptional children, the issue of child abuse and neglect is particularly relevant. Besides being skilled in the identification, assessment and program planning for children with complex learning needs, special educators have begun to work cooperatively with parents. Although familiar with the diagnosis of handicapping conditions, special educators are not necessarily familiar with the identification of abuse or neglect. Nor do they incorporate procedures into an Individualized Educational Program (IEP) which meet the special needs of abused or neglected children. However, for those who serve handicapped children it is important to know that some children may be abused or neglected because of a handicap, others may become handicapped as the result of abuse or neglect. Research has shown that many children who are abused or neglected are in need of special educational services (Kline and Christianson, 1975).

The fact remains that school personnel are in a prime position to prevent, identify and treat child abuse and neglect. Therefore, it is critical that administrators, teachers and special resource persons become aware of their legal responsibilities, the responsibilities of other professionals and the need for a collaborative community effort to respond to the special needs of abused and neglected children and their families.

Several major points may be identified which are of administrative concern to general and special educators alike. It is the intent of this paper to:

- present criteria for recognizing abuse and neglect
- describe current reporting responsibilities
- review the community intervention process, describing the role and function of a multidisciplinary team
- show how policy development is a major line of defense for educators
- offer recommendations for school personnel

The rights of children are not limited to that of a free and appropriate education—all children have the right to be protected from harm. The fact that these rights exist imply a corresponding set of duties or responsibilities on the part of professionals.

The Identification of Child Abuse and Neglect

According to the federal definitions (P.L. 93-247) child abuse and neglect is "the physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby." Generally, abuse refers to acts of commission such as beating or excessive chastisement; neglect, to acts of omission such as the failure to provide adequate food or emotional care (HEW 1975). Differences in normal or acceptable child care practices in various cultures or communities *must* be taken into consideration when an instance of abuse or neglect is suspected.

Certain *behavioral* indicators are usually present in children who have been physically or emotionally abused. Many of these behaviors are readily observable. Some bear striking resemblance to the behaviors of children receiving special education services. For example abused or neglected children can exhibit:

- overly compliant, passive, undemanding behaviors aimed at maintaining a low profile, avoiding any confrontation with a parent or caretaker that could lead to abuse
- extremely aggressive, demanding rageful behaviors caused by repeated frustrations at getting basic needs met
- overly adaptive behavior in response to unresolved needs of the parents
- developmental lags

Mildly abused children receive a degree of affection from their parents, but not enough to meet their emotional needs. Frequently, such behaviors as hyperactivity, temper tantrums, short attention span or aggression will result. The more severely abused children have learned not to expect love or affection. Many may appear dependent, inordinately withdrawn, afraid of physical or emotional contact.

Physically abused children bear indicators of their injury (bruises, welts, burns, lacerations, fractures). Upon medical examination many will also have evidence of internal injuries. Suspicion may be aroused if an injury is inconsistent with the child's age or explanation offered. Some abused children are behavior problems, others may be abusive in order to receive attention.

In its most simple form, *neglect* is defined as the chronic withholding of necessary physical and emotional support for a child. Extreme care must be taken in asking whether or not: there is evidence of physical or psychological harm to the child; the neglect represents an intentional act by parents or caretakers; and, parents, caretakers or the community can be held responsible for causing neglect. Children who are abandoned for long periods of time or lack proper supervision may be neglected. Those who are denied adequate clothing, medical or dental care, education, nutrition or shelter may be neglected. Poverty alone cannot be equated with neglect. Many suspected cases of neglect could be the result of differing cultural expectations or values or child rearing practices.

Sexual abuse is that which is perpetrated on a child by a member of that child's family group and includes not only sexual intercourse but also any act designed to stimulate a child sexually or to use a child for the sexual stimulator, either of the perpetrator or another person. It has been postulated by some researchers that sexual abuse is an extreme manifestation of a family breakdown. Besides a feeling of low self-esteem on the part of the abuser or inadequate coping skills, there may be evidence of alcoholism, lack of social contacts or a high stress situation (death, divorce, loss of job). While positive physical indicators of sexual abuse are apparent in a medical examination, a child may give more observable evidence by pain, itching, bleeding or spotting. Sexually abused children, especially young children may retreat to fantasy worlds. Sometimes giving the appearance of being retarded. Teenagers may act out their anger in aggression towards others.

The most difficult form of abuse to identify is *emotional maltreatment;* these children may be subject to extreme criticism or demands for excessive performance or witholding of physical or verbal contact. Emotional maltreatment or mental injury usually occurs in cases of physical abuse or neglect. This form of abuse has been found to have a "decidedly adverse effect on a child's learning ability, achievement level and general development. The strongest indicators are unaccountable learning difficulties and changed or unusual behavior patterns (DHEW, 1975)."

Educators responsible for both pre-school and school age children observe children closely over a long period of time and are therefore in a position to both identify cases of abuse and neglect as well as monitor a child or his or her family's progress. Frequently the school or day care center is the only source of available nurturing for these children. Once identified, suspected cases of abuse or neglect must be reported to the responsible agency.

Reporting

Although each of the 50 states and the District of Columbia have reporting statutes, a general examination of the statutes would reveal certain differences. The major areas where differences occur include:

- the type of abuse which must be reported
- the specific categories of people who must report
- when the report is made
- the manner of reporting
- the receiving agency
- and the degree of immunity for those who report

Attention should be brought to the fact that many states are currently in the process of amending their reporting laws. Besides expanding the definition of what is reportable to include sexual abuse and neglect, the current trend is to direct all reports to child protective services and establish clear requirements for child protective investigations.

This first step is the formal procedure whereby an individual is required to report a suspected case of abuse and neglect presents his or her suspicions to the agency responsible for receiving such reports. Certain individuals are designated in each state with this reponsibility. Originally only medical personnel were obligated to report, however, as the definition of abuse has expanded to include more than physical abuse, other community groups became involved in the identification process.

The receiving agency varies from state to state, therefore it is necessary to refer to state statute to determine which of the agencies (state or county department of social services, law enforcement, juvenile court or probation, the county health department) is responsible. Statutes also specify whether reports are made in oral or written form and the time limits for reporting. Each state reporting law includes an immunity provision for reports which are made in good faith, therefore making successful litigation against the reporter impossible. Most states attach penalties for failure to report. Criminal prosecution is rare for failure to report. However, under the law of civil negligence if it can be proven that a person willfully failed to report a case of abuse or neglect suit may be brought for injuries. For instance in a recent California decision, *Landeros v. Flood* (1976) the state Supreme Court ruled that a doctor and hospital may be liable for malpractice. Given the increase of malpractice suits generally, it is conceivable that school personnel could be placed in a similar position. Questions have arisen over a potential conflict between the state child abuse reporting laws and the Family Educational Rights and Privacy Act. According to recent clarification by the Education Commission of the States, the following HEW guidelines apply:

> "Reports based on information obtained from education records may be disclosed without obtaining parental consent in two instances of special concern to child abuse authorities:
>
> "(1) Reports to state and local authorities required under state mandatory reporting laws passed prior to November 19, 1974 do not require parental consent to be released. State laws passed *after* November 19, 1974 are, however, not included in this exception. States which have amended their pre-November 19, 1974 laws to require mandatory reporting must, according to HEW, seek interpretation at the state level as to the effective date of the amendment. The question is whether or not the amendment can be considered effective as of the date of the pre-November 19, 1974 act. HEW advises that a state would have 'to determine whether a given amendment is so basic as to have destroyed the nexus with the original (effective date of the) statute.'
>
> "(2) In an emergency, school officials may release information to appropriate persons in order to protect the health or safety of the student or other persons. Factors to be considered in determining whether or not to disclose such information are:
>
> (a) the seriousness of the threat to the health or safety of the student or other individuals;
> (b) the need for the information to meet the emergency;
> (c) whether the parties to whom the information is disclosed are in a position to deal with the emergency; and
> (d) the extent to which time is of essence in dealing with the emergency.
>
> "These two categories cover the bulk of child abuse reporting actions. One final means by which child abuse information is available is if it does not constitute an education record. The two categories above deal with information which is contained in education records. HEW has pointed out that information based solely on personal observation, such as classroom observation, is not an education record; and, therefore, not affected by the Act. Secondly, information maintained in a certain manner, which constitutes the records of a law enforcement unit, does not fall within the definition of education records and is, therefore, available
>
> "The final regulation under FERPA became effective on June 17, Secretary Mathews intends to review the regulations after one year and will initiate comments concerning changes to be made." (HEW, 1976).

After Reporting: Case Management and Referral

It is not uncommon for school personnel to express a reluctance to report a case of child abuse and neglect. Very personal reasons, such as a fear of civil or criminal liability, as well as professional concern over making a false report or jeopardizing a relationship with a child and his or her family are behind this reluctance. Many feel that incidents of abuse and neglect can be handled, without outside assistance, particularly if experience has proven that referral to the designated agency has been inadequate. A parallel may be drawn to the child in need of special education. Appropriate professional practice dictates that a handicapped child will receive a proper assessment and an individual educational program based on his or her special needs. An extensive array of procedural safeguards exist to support a handicapped child's right to a free and appropriate education. Children in need of a variety of special educational services frequently work with a number of professionals. Children who are abused or neglected and their families have many special needs which require the combined efforts of professionals from several community agencies. Yet, the treatment of abuse and neglect usually is focused on the parents or caretakers. Children do not receive comparable treatment and are frequently "lost" in the shuffle of school personnel who are not quite sure how to deal with the apparently mysterious functioning of social services. Even more ironic is the fact that schools and licensed day care facilities have access to highly trained cadre of qualified professionals more than willing to supplement a treatment program.

In a recent report by the National Institute of Mental Health, *Child Abuse and Neglect Programs: Practice and Theory*, the authors point out that much of the literature available on treatment programs is of a very general nature. Moreover, few objective criteria exist which can be used as a basis for determining the best treatment modality, and none measure success in treatment. This fact is particularly true when referencing available information on the role of the educator in the prevention, identification and treatment of child abuse and neglect. The emphasis for educators so far has been primarily on identification and reporting responsibilities.

Research has shown, however, that once a report is made to the appropriate agency, the most effective case management and treatment process is dependant on the collaborative efforts of a variety of service agencies. A successful broad based approach must then focus on the complete set of environmental and physiosocial factors affecting the family. These may include the services of day care, foster care, homemaker programs, or rely on medical, legal, educational or financial support.

Although the investigation of a reported case is usually conducted by a social worker or the police department, referral should be then made to a representative community group. Interviews, observational and other data, are obtained during an investigation to determine: if abuse or neglect is occurring; if the child is at risk; and, whether or not the child should be removed from the home. While every effort is made to keep children and their families together many children must be provided emergency placement often in a crisis nursery or foster home. Once an assessment is completed of the family's emotional and functional capacities a case decision is made based on available options determined by the law, agency mandates and available resources. However, guidelines or regulations for these case plans are rarely as specific as those required for handicapped children.

Although the impact of different treatment plans have not been systematically measured, research indicates that intervention is successful for parents. Children, however, are usually seen briefly and excluded from the therapeutic process. Foster care also tends to be more geared to the needs of the parents. Parental options for treatment could include one-to-one therapy, couples or group therapy. Programs studied in the NIMH report indicated that treatment averaged approximately 2 years, with a range of 6 months to 7 years. Findings revealed that programs which had a short-term casework orientation were more likely to emphasize behavior rather than personality change and offer a more structural form of therapy with emphasis on short-term goals. Programs which offer long-term casework are more likely to emphasize exploration of feelings, reparenting or personality change. One of the most striking conclusions of the study was that those working with cases of abuse and neglect generally lacked training in child development and professional experience with children.

While the responsibility for coordinating services usually rests with the social worker, no single agency is able to provide all of the services needed for a family. In order to prevent fragmentation of services there must be a collaborative effort by representatives from education, law enforcement, health care and social work to plan a total treatment program for children and their families.

Multidisciplinary programs exist for the prevention and treatment of abuse and neglect, for example: the hospital-based programs; private non-profit volunteer programs; public social service agency based programs and community based teams. Most draw heavily from professional groups other than educators; others involve school primarily as a source of identification and referral. Few make effective use of school personnel in the treatment process. Formulation of a multidisciplinary team within a community most often is based on an agreement among various service agencies to pool their resources with each responsible organization contributing staff time. Often the first step is to establish a task force to review procedural guidelines. This would normally be followed by a joint participation in handling cases of abuse and neglect and the formulation of community wide information programs on the issue and local reporting and treatment procedures.

Policy Development

An increasing number of school districts have established effective policies which outline specific reporting procedures for school personnel. Corresponding policies represent an educational commitment to a major line of defense against child abuse and neglect. A nationwide assessment of current education policies and practices was recently conducted by the Education Commission of the States (ECS). The findings and implications of this study have recently been published in a report by ECS (April 1976) which specifically discusses the role of education and offers guidelines for policy development.

Representatives of 390 selected education groups and institutions were interviewed in order to collect information, among other things, on:

- existing policies, procedures and regulations on identifying and reporting child abuse
- the nature and extent of their training activities for school personnel.

Of the professional education groups studied, the tendency was to adopt policy before initiating programs or activites. Education institutions in the study sponsored more activities or services for abused children than had policies regarding child abuse. Although institutional involvement appeared to focus on identification and reporting, respondents cited planning activities in policy development and staff training.

Because the school system is the most comprehensive social resource for the total growth of a child, educators are considered a major resource for helping abused children and their families. However, the ECS study indicates that educators have had a very limited role in the prevention of child abuse and neglect. Possible reasons offered include a lack of training and relevant information as well as the doubt that their involvement could improve the situation.

Points for consideration are presented in the study for the development of purposeful policies which encourage policies on child abuse and neglect, which are in compliance with state law.

The ECS guidelines suggest inclusion of the following elements in policy statements:

- A brief rationale for involving school personnel in reporting.
- The name and appropriate section numbers of the state reporting statute.
- Reportable conditions as defined by state law.
- The person or agency to receive reports.
- The information required of the reporter.
- Expected professional conduct by school employees.
- The exact language of the law to define "abuse" and "neglect" if necessary, explain, clarify or expand.
- The method by which school personnel are to report (if appropriate, the list telephone number for reporting) and the time in which to report.
- Whether or not there is immunity from civil liability and criminal penalty for those who report or participate in an investigation or judicial proceeding; and whether immunity is for "good faith" reporting.*
- Penalty for failure to report, if established by state law.
- Action taken by school board for failure to report.
- Any provisions of the law regarding the confidentiality of records pertaining to reports of suspected abuse or neglect.

In July, 1974, the Montgomery County Public Schools (MCPS) of the State of Maryland, became, through PROJECT PROTECTION, one of three school systems in the nation to receive a Title II grant from the U.S. Office of Education for the purpose of exploring multidisciplinary approaches to the problem of child maltreatment. Now completed, MCPS benefit from the accomplishment of the project goals: policy revision, staff development, direct service and curriculum development. Moreover, PROJECT PROTECTION, has been recognized to have massive impact on the public and private education sectors.

The policy revision phase was accomplished in the first three months and has served as a model to school systems throughout the nation. The resulting policy and staff development has significantly increased the MCPS' level of school reporting of incidents of child abuse and neglect.

> The Montgomery County Board of Education, recognizing the serious local, State and national problems of child abuse and child neglect, affirms its position that the Montgomery County Public Schools shall cooperate vigorously to expose these problems by early identification of abuse or neglect and by reporting suspected cases to duly constituted authorities whether or not substantial corroborative evidence is available. School employees are in a unique position to discover potential cases of abuse and/or neglect of children and youth through the age of seventeen years. Employees are required by Maryland law to report suspected cases of child abuse to the Department of Social Services or Juvenile Section of the Montgomery County Police Department. Suspected child neglect is to be reported to the Department of Social Services. Effective action by school employees can be achieved through recognition and understanding of the problem knowing the reporting procedures, and participating in the information programs in child abuse provided for Montgomery County Public Schools employees.
>
> Guidelines have been developed to provide direction for staff members in reporting suspected child abuse or child neglect cases. Staff personnel should be aware that by statute they are immune from any civil and/or criminal liability when reporting suspected child abuse and from any civil liability when reporting suspected child neglect. Failure to report, on the other hand, might result in legal action being brought against a staff member and disciplinary action by the school system. Any doubt about reporting a suspected situation should be resolved in favor of the child, and this situation should be reported immediately.

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*While every state provides immunity for those reporting child abuse, many do not provide immunity for reporters of child neglect. School systems in these states may be able to extend immunity to school personnel via the state public school laws. Many of these laws grant immunity to educators who act under a requirement of school law, rule or regulation. By enacting a regulation requiring school personnel to report suspected abuse and neglect, school systems can ensure full immunity to their employees who report.

> Any Montgomery County Public Schools employee who has reason to believe that a child has been abused or neglected shall report this information in the form and manner provided.
>
> To maintain awareness on the part of all professional staff members, the Montgomery County Public Schools will provide periodic staff development on the subject of child abuse and neglect.

Corresponding regulations specify school reporting procedure for both cases of child abuse and child neglect. Definitions of abuse and neglect are included as part of the policy statement.

Subsequent staff development in Montgomery County provided 6,900 staff members in each of the county's public schools with information on their legal reporting responsibilities and immunity provisions; the identification of child abuse and neglect; and proper referral procedures.

The direct service component provided social work service to nine county non-public schools. This aspect focused on early detection of abuse and neglect as well as the prevention of abuse and neglect.

In order to reduce the number of abused and neglected children a course of study was prepared on the child maltreatment syndrome for use at the secondary level. The curriculum now in its pilot phase of instruction, consists of six instructional units, each concerned with a different aspect of child maltreatment.

The policy statements of many professional associations relfect national support of this effort. Some policies are more comprehensive than others in that they stress various approaches to prevention or treatment. For example, the American Association of School Administrators recommends that its members become "active protectors of abused and neglected children and use the resources of the district and the law to see that such abuse is stopped." In addition to cooperating in the identification and reporting of abuse and neglect, the National Association of State Boards of Education has adopted a policy which encourages State and local school boards to adopt policies and procedures to cooperate with all agencies concerned with this problem. Specific language aimed at treatment is found in the policy of the Council of Chief State School Officers:

> The Council calls upon all states to review and revise statutes for the mandatory reporting of suspected abuse and neglect of children so that legislation (1) expands the definition of abuse to include not only physical but also emotional and sexual abuse, (2) includes a provision for preventive and remedial measures and not simply punitive ones, and (3) increases the number of persons required to report to include teachers, social workers and other professionals coming into contact with children in addition to medical personnel. Uniformity among state laws is encouraged. State departments of education must provide training for teachers and administrators in the recognition of abuse, legal reporting requirements and methods of working with abused children and child abusers.

The policy statement of The Council for Exceptional Children (CEC) encourages schools to go beyond their traditional role as coordinators or users of other community services and lead the way in developing new and experimental forms of comprehensive child and family services. In 1974, the CEC Delegate Assembly which represents the Council's 900 local Chapter units, 50 State and 13 special interest divisions, adopted a resolution which defined "abused and neglected children as exceptional children" and encouraged "efforts to develop a role for educators in child protection." During the past year CEC has offered training to educators and other interested persons in prevention, identification, and treatment of child abuse and neglect. One of the results of this effort has been to stimulate policy development on a grassroots level. Another has been to incorporate professional training activities into a number of preservice and inservice programs offered through institutions of higher education as well as local school districts.

Once initial reporting procedures are set forth in policy with the assistance of other responsible agencies, educators are encouraged to expand policies and guidelines to include the areas of prevention and treatment.

Implications for Educators—Minimum Legal Responsibilities and Maximum Professional Responsibilities

That children have a right to be protected from physical and mental injury is a right that cannot be denied. Furthermore, this right demands a certain legal responsibility on the part of professionals who serve children. In the case of child abuse and neglect, educators in most states are legally obligated to report a suspected incidence. Failure to do so may be punishable by a civil or criminal action. The question remaining, however, is where does professional responsibility for a child end. Does it end with the minimum fulfillment of the legal requirement or with maximum involvement beyond existing procedures?

If it is accepted that children who have been abused or neglected run a risk of having certain physical or emotional needs then there is a strong likelihood that a response to some of these needs will be the partial responsibility of those who provide special services for children in a school setting. Although not included in the definition of a handicapped child as set forth in Public Law 94-142, these children would certainly profit from an individualized educational program, particularly if that program involved the child's parent or caretaker as a cooperating partner. While such a program is concerned with educational needs, the procedural requirements may serve as a stepping stone for a more expansive treatment program.

The troublesome reality that most abused or neglected children are not receiving appropriate treatment, particularly if one considers that there is a relationship between violence in our society and abuse. (For example, Charles Manson & Sirhan Sirhan were found to be abused as children.) However, if an individualized educational program is an effective management tool for service delivery and there is a cadre of highly trained professionals in schools, it seems that there exists a strong potential for providing some of the necessary treatment.

Besides designing ways to help children who have been hurt, it is critical to examine alternatives to prevent abuse or neglect from occurring in the first place. Parent education thus becomes the primary method to prevent this occurrence. With respect to child care, optional educational programs can be designed to provide information and skill in the developmental stages in normal child growth and development. Supplemented with information on health care, nutrition and behavior management, courses or programs represent an invaluable defense against abuse and neglect.

Parent education can be offered in a variety of settings which include adult education programs, community colleges and as part of an elementary or secondary school curriculum. Incorporated into the educational design should be information on basic home management, stress control and where to find assistance if necessary. Again, educators are in an excellent position to either provide this type of education or cooperate with another sponsoring organization.

Numerous examples may be found in a variety of special education programs which incorporate parent education as a major participant in a child's education. Moreover, the implementation of P.L. 94-142 should further strengthen the parent-professional partnership.

Although the problems inherent in cases of child abuse and neglect are quite complex, there are a series of definite steps which may aid in the solution of the problem. Three distinct phases may be identified which stimulate the educators participation in developing community based alternatives to the destruction of families in need of help: information; policy development; and, implementation. All require community support. While policy development appears as central to this process, it is dependent on access to information and made active in implementation. It is therefore recommended that educators consider their professional and legal responsibilities in the following information, policy and implementation areas.

Information Areas	**Policy Considerations**	**Implementation**
1. Identfication	Educational personnel need to be informed of the four types of child abuse and neglect	• Pre-service or in-service training tor educators
2. Reporting Requirements	School personnel need to know their legal responsibilities	• Policy development • Training
3. Prevention	Educators need to take an active part in the prevention	• Parent education courses adults & students in appropriate parenting behaviors, child development, family life, discipline, aggression.
4. Treatment for children	Guidelines are needed which permit the development of in-school treatment for abused and neglected children	• Counseling • Programs to meet the physical and emotional needs of children
5. Assistance to families	Support for family needs	• Counseling • Childcare: day care, after-school, crisis nurseries; • Programs to involve non-abusive parents to help abusive parents.
6. Multi-disciplinary efforts	Cooperating agreements to prevent, identify and treat abuse and neglect	• Policy development • Task force • Team referral • Cooperative training

Benefits may be implied for children, families and many professional groups as interagency cooperation expands.

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APPENDIXES

Appendix A

PROGRAMS SERVING THE EMOTIONALLY HANDICAPPED

Information pertaining to exemplary programs for the emotionally handicapped was obtained through direct requests to Regional Resource Centers (RRCs), the Coordinating Office for Regional Resource Centers (CORRC), the Regional Resource Center Training and Communication Committee, and the National Association of State Directors of Special Education (NASDSE), which solicited input from state directors of special education through the Liaison Bulletin. Many more programs (87) were identified than were possible to present during the conference.

Following is a Compendium of those twenty-four programs that responded to a request by mail for a brief description of their activities. These programs are in addition to those presented at the conference. This information has been compiled here so that state and local administrators may benefit from increased awareness of existing programs that serve this population. To further assist readers, the names and address of contact people have been provided to facilitate acquiring additional information about programs that have a particular relevance to their needs.

Contents

Page

A Group Music Program for Autistic-Like Children — *Minneapolis, MN* 81

Airline Park School Autistic Services — *Baton Rouge, LA* 81

An Educational Model for Autistic Children — *Orlando, FL* 82

Children's Behavioral Services (CBS) - *Las Vegas, NV* 83

Delinquency Prevention Center Program — *Huntsville, AL* 83

Diagnosis and Treatment of Childhood Depression — *Pittsburgh, PA* 84

East Detroit High School EI-LD Special Services Program — *East Detroit, MI* 85

Edgewood Children's Center — *Webster Groves, MO* 86

Education in Living — *Fort Worth, TX* 87

ERC Project — *Medford, OR* 87

Green Bay's Cooperative Approach for Programming Emotionally Disturbed Children — *Green Bay, WI* 88

Jordan Resource Center — *Midvale, UT* 89

Lafayette Program for ED/LD Students — *Lafayette, IN* 89

Minneapolis Public Schools Programs for Students with Serious Adjustment Problems — *Minneapolis, MN* 90

North Durham County Re-Education Project — *Durham, NC* 92

North Metro Children's Center and Project Spring — *Atlanta, GA* 92

Project SPEED — Columbia, SC 93

Project SPRING — *Atlanta, GA* 94

St. Paul Programs for Social Development (PSD) — *St. Paul, MN* 95

SBC Project — *St. Louis, MO* 95

School Within a School Program — *Davenport, IA* 96

The Central Kentucky Re-Ed Program — *Lexington, KY* 97

The Learning Place — *Syracuse, NY* 97

The Re-Ed School of Kentucky — *Louisville, KY* 98

Project: A GROUP MUSIC PROGRAM FOR AUTISTIC-TYPE CHILDREN

Director: Mrs. Lyle Chastain

Mailing Address: Program for Autistic-Type Children, 202 Pattee Hall, 150 Pillsbury Drive, S.E., University of Minnesota, Minneapolis, MN 55455

Phone Number: (612) 373-5267

Project Description:

The Group Music Program is an integral part of the Program for Autistic-Type Children in the Department of Special Education at the University of Minnesota. Although the primary focus of the Autistic Program is on teacher training at the Masters Degree level, an extensive outreach component has been added in the last few years. Over 50 children a year are seen for educational evaluation, and school districts throughout Minnesota and in nearby states are given assistance in establishing public school based programs for children with special needs.

The Group Music Program describes in detail what we have learned about using music as a medium for facilitating the development of autistic-type children. The program was established because we felt the children definitely were capable of positive social interaction, group participation, cooperation, and spontaneous speech despite the behaviors they demonstrated when they first arrived. Most of these concepts and procedures were learned directly from the children—from observing their reactions to new and different techniques. This ability to involve close observation of the children themselves is perhaps the most essential element to using this material effectively.

Our program is a demonstration school, open to observers upon appointment. We also present workshops on autism, our music program, and related topics.

A handbook describing in detail the various songs used in the program as well as the objectives and procedures for using these songs will be available soon. Accompanying the handbook are four video tapes illustrating songs used in the music program (Tapes I and II), various prompting techniques used by teachers during music (Tape III), and some of the techniques used in leading the music sessions (Tape IV).

Although the handbook discusses specifics about the program and about the songs, its purpose is not to give a step-by-step method that can automatically be applied to another group of severely handicapped children, but rather to present certain concepts and procedures that can be adapted for use with various groups of children.

Project: AIRLINE PARK SCHOOL AUTISTIC SERVICES

Director: Bob Schedgick, Ph.D.

Mailing Address: Division of Special Education, Department of Education, Baton Rouge, LA 70801

and

Director: Alberto Deschapelles, B.A.

Mailing Address: Airline Park School, Camphor Drive, Metairie, LA 70003

Phone Number: (504) 389-5291

Project Description:

Two of the major problems related to the education of severely and multiply handicapped autistic children and youth are providing delivery of educational services to the child and offering support programs for the parents. Our program has provided these services for two years in a public school in an urban school district in Louisiana. The program, located in an elementary school, is fully supported by the local school board. The parish offers no additional financial support which is not available to all other special education classrooms. It is not a demonstration project, but an operational program. This program has developed and provided educational services for both the parent and the child in a public school setting. The program is built on the principles of individualized planning and instruction for both the child and the parent. In addition, the teacher uses a curriculum model which encourages the learning and the generalization of skills. Finally, the entire program is implemented using a five phase process: assessment and planning, problem solving, instruction, normalization, and group instruction.

Children placed in the program have been identified and evaluated by state supported multidisciplinary teams consisting of a psychologist, audiologist/speech pathologist, educational consultant, and social worker. After the initial evaluation, an informal evaluation process is continued by the teacher in the classroom.

The assessment and diagnostic procedures are related directly to the content of the curriculum model. When the pupil enters the classroom his skills are assessed by presenting him with the tasks listed on a Behavior Characteristic Progress Chart (BCP). After each of these items is administered to the pupil, the content of the pupil's educational plan is determined.

The content, scope, and sequence of the curriculum is conceptualized into three general program stages. In stage one, the pupil learns such basic skills as attending to simple auditory, visual, and verbal stimuli, self-help skills, and production of sounds. At stage two, the pupil begins to learn more complex visual-motor skills. The final stage includes the teaching of basic academics, vocational skills, personal care and social behavior. As the child/youth acquires the majority of the skills at one stage, he progresses to the next.

The effectiveness of the classroom is evaluated in several ways:

1) Data are recorded daily for selected instructional objectives and performance criteria are set.
2) The pre-post performance of each child is compared, using the TARC and Camelot Behavior Checklist.
3) The total number of objectives completed on the BCP are counted for each year.

These procedures allow the teacher to evaluate each child's progress in a variety of skill areas and how he performed selected tasks.

The physical space of the classroom is arranged to accomodate the number, ages, and behavioral characteristics of the pupil. Ideally, classrooms should have a maximum of four children with at least one teacher and one aide. The rooms are equipped with materials appropriate for conducting the specific instructional programs.

The classrooms are located in a school which houses regular and special education programs and has facilities such as a playground and cafeteria which are shared by all pupils. A self-contained room is used to conduct the program. The restrooms are close by so that they may be used for toilet training.

The length of the school day is determined by the pupil's ability to attend to individual tasks. At the beginning of the school year, the length of the school day may be as short as one hour (or shorter if necessary), and may be extended gradually as the teacher gains control over the child's behavior and as the pupil's attending skills increase.

The goals of the instructional program extend beyond the walls of the school to include the teaching of appropriate skills and behavior in the pupil's home. The teacher encourages the parents to assist the pupil in reaching these goals. The parent training program is continuous for those parents who are willing to participate. Reading assignments are provided and regular training sessions are scheduled. The appointments are set up with each parent, at which time the teacher supervises, models, or works with each parent. The parent implements the program at home and records data as the program progresses.

The parent training program begins with a careful analysis of how the parent motivates the pupil, presents materials, gives verbal directives, gives feedback, and reacts to the pupil's errors. At the same time, the parents are interviewed as to how they interact with their child. During several interviews, the teacher also makes observations about the parents' motivation to participate in a training program, assesses how family problems may affect the parents' commitment.

Observations made during the training can give major clues to the teacher about whether the parent will want to proceed with the training. Some parents will indicate that they don't want to participate, others will find it "too difficult", some will find that their family problems are overwhelming and more important, and there will be those parents who will say "yes, but . . . ". These excuses are accepted as an indication that a different type of strategy may be needed. In these instances, parents may be asked to participate in other ways as providing rewards or making simple materials. It is important that, while parents are not "forced" to participate, the teacher adopt a plan which may eventually lead to the development of a cooperative relationship with the teacher and parent in educating the child.

Project: **AN EDUCATIONAL MODEL FOR AUTISTIC CHILDREN**

Director: Mrs. Gerri Brown, Autistic Project Administrator

Mailing Address: Gateway School, 4000 Silver Star Road, Orlando, FL 32808

Phone Number: (305) 293-0680 or 293-0661

Project Description:

This Title VI-B project assumes responsibility for the demonstration and dissemination of curricula, techniques and assessment procedures relevant to total program development for student populations age three through vocational training. Throughout the three years of the project various written and visual materials have been produced and disseminated within the State of Florida and to interested personnel from any state requesting such information. Available materials include four written volumes detailing all components of the program from facility cost and structure to actual training procedures for aides. In addition, sound-slide presentations as well as video tapes are available for loan. With the use of all products produced by the project, any school district expressing the desire to replicate the model will be able to accomplish this task with ease.

Within the program, housed at a public school within the county, direct services to children, parents, volunteers and college students are provided. The student population served meets the criteria listed in the definition of the "autistic" child which is available through the National Society of Autistic Children. Program activities for the student population range from one-to-one intensive behavior shaping through prevocational training with industrial power tools. Student-teacher ratio varies according to the needs of the students (students requiring one-to-one instruction for any interaction to those who are able to work independently). Children are grouped according to functioning level and needs within the classrooms and language therapy is provided to all students. The cost per pupil for the program after initial starter costs, and including teacher salaries, benefits, transportation, overhead, repairs, etc., is $3,500 per child for an 11 month period.

Parent education is an essential component of the program and written materials are available concerning the complete program, which includes home based training. Utilization of community resources is another essential element of the program and the classrooms serve as a community based field setting for education and psychology majors from universities.

Exit criteria from the program include specific skills which are required prior to consideration for transition. There are currently 27 students being served in the program, with eight students having achieved a successful transition out of the program in the past two years.

Project: CHILDREN'S BEHAVIORAL SERVICES (CBS)

Director: Joe M. Burnett

Mailing Address: 6171 West Charleston Boulevard, Las Vegas, NV 89102

Phone Number: (702) 870-9141

Project Description:

Children's Behavioral Services (CBS) is an agency of the State of Nevada, Division of Mental Hygiene and Mental Retardation, Department of Human Resources. Children under the age of 13 who have not yet entered the seventh grade, and who display emotional, behavioral and social problems, are eligible for service. The major functions of the agency are to provide prevention, early detection, and treatment of emotional problems. The behaviorally oriented services of the center focus on family involvement. CBS believes that parents often can be the best teachers of their children and that working with the family produces the best results.

The building complex housing the agency includes clinical and administrative offices, conference rooms, and four residential units. Each residential unit is designed to accommodate one teaching parent family and four children in residential treatment. Direct observation is available into the residential and classroom units as well as some of the clinical offices. The agency's closed channel audio-visual system also provides an important observation, evaluation and training resource.

Clinical services provided for severe, moderate and mildly disturbed children include child counseling, individual and group parent consultation, social skills training, preschool and elementary classroom programs, language acquisition training, foster parent training and residential services in both campus and community based homes.

One of the unique features of the agency is the professional teaching parent residential program in which a professionally trained couple live with four children in a family-like setting. These residential units, extensions of the Achievement Place Model, include units for both the severely behaviorally disordered and autistic child. By using this residential model, the agency is able to maximize quality residential services in a normalized atmosphere and at a cost significantly below traditional residential models.

Project: DELINQUENCY PREVENTION CENTER PROGRAM

Director: Mary Jane Caylor, Project Director

Mailing Address: Huntsville City Schools, P.O. Box 1256, Huntsville, AL 35807

Phone Number: (205) 539-2111, Ext. 303

Project Description:

The Delinquency Prevention Center is funded by a grant from the Alabama Law Enforcement Planning Agency through the City of Huntsville to the Huntsville City Schools.

In addition to the coordinator, staffing for the Delinquency Prevention Center includes a behavioral specialist, two certified teachers, three mental health technicians, and a secretary. The program director also directs the Special Education Program for the Huntsville City Schools.

The objective of the Delinquency Prevention Center program is to alleviate delinquency in the Huntsville City School area through a "focused educational environment" for youths who are on the verge of expulsion from the regular school. This "last-ditch effort" allows the student to continue education without interruption. The primary effort of the Center is directed toward changing behaviors which are not acceptable in a regular classroom and increasing those behaviors which facilitate coping with the regular school environment. The total effect then is to prepare the student for readmission into the regular school environment.

The academic program of DPC is designed to meet a variety of student needs. The DPC presently has on roll students ranging in grade level from the fourth through the senior year in high school. The DPC serves students who have been diagnosed as educable mentally retarded, those diagnosed as having learning disabilities, and those measuring average to above average in intellectual functioning and achievement. A diagnostic/prescriptive program is provided for each student. This approach includes evaluation using tests such as the Key Math Diagnostic, the Wide Range Achievement Test, the Durrell Analysis of Reading Scale and the Slingerland Test for Specific Language Disability. Using the results of these evaluations as well as information gleaned from interviews with the parents and student and from a review of previous academic and behavior history, an educational program including desirable academic and behavioral objectives is designed to meet the particular needs of each student. Students receive academic credit for attending DPC just as they would if attending a regular school.

At DPC, the primary method of obtaining behavioral change is the token economy system. Students win points for appropriate behaviors or receive time-out or loss of tokens or points for inappropriate behaviors. The phase-back of students into the regular classroom is dependent upon their reaching certain behavioral criteria. The criteria specifically include earning a total of 1800 behavioral points within a fifteen-day period for a trial phase-back; or for those students who have returned to DPC because of violation of phase-back rules, the earning of 3000 behavioral points within six weeks is required. The behavioral program, monitored by the mental health technicians and behavioral specialist, includes a system for reliability checking. Individual and group counseling are also included in the program. The techniques used in counseling include both assertive and rational behavior training.

The success or fail rate of the Delinquency Prevention Center is determined by the number of students assigned to the Center and the number of students reassigned to the normal school environment without having to be expelled by the Board of Education. Since inception, the Delinquency Prevention Center has served a total of 48 students. Of these, 26 have been phased back into the regular school environment; two have dropped out of school; and one has been expelled after reassignment to the regular classroom.

In summary, a variety of behavioral and educational techniques have been used with students who have been disruptive in the regular school environment. These techniques have been successful not only in changing the behavior of the student in the school setting, but apparently have also had a definite effect in preventing delinquency in the Huntsville City Schools' area.

Project: **DIAGNOSIS AND TREATMENT OF CHILDHOOD DEPRESSION**

Director: Theodore A. Petti, M.D.

Mailing Address: Western Psychiatric Institute and Clinic—Children's Psychiatric Intensive Care Service, 3811 O'Hara Street, Pittsburgh, PA 15261

Phone Number: (412) 624-2967

Project Description:

The purpose of this project is to develop instruments to aid in screening and following the course of depression in children, and to determine effective treatment modalities. Subjects will include 45 children, ages six to twelve years, to be studied in a double-blind controlled study of children who have been depressed at least one month prior to hospitalization.

The children are housed in an 11 bed inpatient child psychiatry service for children who need short-term diagnostic evaluation or treatment within a very structured setting. The average length of stay is six to twelve weeks. The unit has adequate space for two schoolrooms, with a requisite amount of instructional equipment and materials, a gym, a recreational area, a patio, and an occupational therapy department on other floors. There is also a reading room for individualized instruction, a two-way viewing room with audio-visual equipment, a lounge area, and bedrooms housing one or two children. The staff includes a full-time program director, a part-time research coordinator, full-time teachers with Master or Bachelor degrees, educational aides with Bachelor degrees, a registered school psychologist, a part-time clinical psychologist, a full-time social worker A.C.S.W., nine registered nurses, eight psychiatric aides and a half-time research assistant plus psychiatric residents, psychology interns, special education students, child care students at both the Associate and Bachelor level, practicum psychology students, medical students, and the clerical staff.

Individual treatment plans are developed for each child and consist of observation for specific behaviors; appropriate medical, psychological and psychiatric procedures; specific therapeutic interventions and pharmacotherapy if indicated. A number of instruments have been modified and developed for use in monitoring the course of hospitalization for both depressed and non-depressed children. The Children's Behavioral Inventory, a 139 item scale, is scored twice daily during specified times. Observational data is collected three times weekly during specified times and is geared to individual problems such as high activity level, appropriate and inappropriate peer interactions, bizarre behavior or vocalizations, temper tantrums, etc. Scales such as the Scale of School Age Depression (SoSAD), the Bellevue Index of Depression (BID), the Teacher Affect Rating Scale (TARS), Children's Affect in Fantasy Evaluation (CAFE), and the School Age Depression Listed Inventory (SADLI) are specifically used for diagnosing and measuring the course of the child's depression or depressed symptomatology with a variety of therapeutic interventions. An in-depth psychoeducational evaluation is given to measure exact levels of intellectual functioning, academic and achievement levels, receptive and expressive language development, visual motor integration, perceptual motor skills, and conceptual levels in specific modality development. A psychoeducational prescription is then written for each child according to his specific strengths and needs, with short-term behavioral goals and recommendations incorporated into his remedial program. Each child is also assessed for both strengths and weaknesses in social skills, and a specific program is instituted when needed.

Specific behavioral interventions are instituted for target behaviors and a program of parent effectiveness training is prescribed when needed. Depressed children will be treated in one of three groups: (1) imipramine group; (2) biofeedback group; and (3) a placebo group which gets all the behavioral, social and psychoeducational interventions the other two groups get. Three and six month follow-up evaluations are conducted to determine whether sustained generalization can be predicted from baseline data. The research protocol calls for six weeks duration.

Difficulties encountered in establishing this program include the inertia of longtime staff members in moving from a custodial to an acute intensive evaluation and treatment approach; instructing and training staff members in collecting reliable clinical data in a structured manner; the integration of research, educational and clinical goals into one program that is striving for excellence in each; and the acceptance of a strong emphasis on the psychoeducational approach to the psychiatric treatment of disturbed children. A major factor in accomplishing all the tasks outlined above is that of appropriate and sufficient staffing and financing. There have been tremendous strains on the system in attempting to implement this program and we anticipate funding for adding staff members who are more trained in cognitive child development, child care, and behavioral approaches, such as a Master's level person with a very strong background in behavioral theory and management who is necessary to oversee the implementation of the multiple programs that have been instituted; three bachelor's level research assistants who can both aid in implementing the behavioral and social skills training approach as well as collect the clinical data; a psychiatric nurse clinician to work with families in getting a good psychiatric history going back to previous generations as well as helping to implement the specific care plans for the child once he is discharged from the unit.

Financing is obviously the major problem to a program such as this. Much lip service is given to psychiatric services for children and to delineating and taking a preventative approach to these disorders. Although moral support may be available, very little financial support is. We estimate that simply by expanding to accomplish these goals our program would cost an additional $60,000 a year.

Project: **EAST DETROIT HIGH SCHOOL EI-LD SPECIAL SERVICES PROGRAMS**

Director: Thomas Buran, Director of Special Services

Mailing Address: East Detroit High School, 15501 Couzens, East Detroit, MI 48021, c/o Cora Houchens, Teacher-Consultant.

Phone Number: (313) 776-9700, Ext. 257

Project Description:

East Detroit High School has a population of 3,000 students in grades 10-12. The EI-LD population is 95 students (35-LD, 60-EI) with three Resource Room Teachers, one Teacher Consultant, one Education Strategist, and one Vocational Coordinator. This program has been in operation three years with 40 students graduated in the last two years.

Our classes are located all over the high school, being "invisible", but having from ten to twelve students and a certified teacher. We individualize for the students in the cognitive, affective and vocational areas, providing classes but working with all departments. All courses are coordinated with the "regular" department heads and teach the same units but provide more "hands on" and practical approaches.

Special courses were designed and initiated because our certified population could not copy notes, read 12th grade texts, or read the tests. Other pre-vocational courses (Personal Growth, Math, and Tutoring) were added to meet pre-entry job needs of all our students.

Students are interviewed by the Educational Program and Placement Committee and if necessary and as appropriate are referred to one or more of the EI-LD Program specialists.

The Teacher-Consultant (TC) for Emotionally Impaired-Learning Disabilities works with high school students previously certified by an Educational Program and Placement Committee (EPPC) as one of the following: 1) Emotionally Impaired; 2) Learning Disabled; 3) Educationally Mentally Impaired; or 4) Physically Handicapped.

The counseling provided these students can be classified into two settings—crisis intervention and caseload counseling.

Crisis intervention techniques are used when a student experiences a situation or an emotion with which s/he is unable to cope. The objectives of crisis intervention counseling are: reduction of anxiety, cognitive restructuring—an awareness of feelings, identification of alternatives, and allowing the student to select his own solution to the problem.

Caseload counseling can be done on either an individual or a group basis. The frequency of such counseling can be classified as follows:

1. Consultative—when the student determines a need to seek the TC's services.
2. Census—when the TC determines a need to see a student.
3. Active—when the student is involved in a regularly scheduled session either individually or as part of a group.

Individual counseling may occur as a preparation for a student's participation in a group or where the TC and the EPPC have determined such a mode to be potentially more beneficial to the student.

The teacher consultant also schedules students' appointments with the Guidance Department; assists the Educational Planning and Placement Committee with the planning and placement of students in the area of personal adjustment; and is available to any staff faculty member/administrator/parent/outside agencies for supportive services, clarifications, referral information, evaluations, etc.

When the student has been referred from the Social Worker for at least two of the following reasons:

1. Chronic academic problems
2. Acute academic problem, failing two or more required subjects
3. Academic performance two or more years below grade level, measured by most recent standardized test. If an adjusted mental age is available, the student must be performing below that mental age.

The Educational Strategist administers the initial diagnostic testing and writes the individual prescription. One method used by the strategist is High Intensity Peer Group Tutoring using certified EPPC students as tutors working with still lower skilled EPPC students on an individually prescribed program designed to remediate reading and math deficiencies. The student and tutor follow the individual prescription each day for fifty minutes. Both student and tutor may earn one-half unit of credit for participation in the program. Each hour is monitored by the Educational Strategist.

The coordinator of vocational-special education works with students who have previously been certified by an Educational Planning and Placement as one of the following:

1. Emotionally Impaired
2. Learning Disabled
3. Educationally Mentally Impaired
4. Physically Handicapped.

The coordinator helps students identify interests, aptitudes, and abilities for individual vocational planning; assists the Educational Planning and Placement committee with the planning and placement of students in vocational education; serves as inter-department liaison with the vocational-special education staff to establish the following:

1. Common units of instruction
2. Reinforcement of classroom instruction
3. Procedures and activities to minimize the number of students presenting problems.
4. Modification of teaching techniques
5. Improving the delivery of vocational education for students (access and entry)

and coordinates job placement and/or continued vocational training upon graduation.

Students who, as a result of a vocational assessment, demonstrate an aptitude and interest in a particular vocational area, may enroll in any of the regular vocational programs where they would be required to complete the minimum state performance objectives.

Project: **EDGEWOOD CHILDREN'S CENTER**

Director: Ralph S. Lehman, ACSW

Mailing Address: Edgewood Children's Center, 330 North Gore, Webster Grovew, MO 63119

Phone Number: (314) 968-2060

Project Description:

Edgewood is a residential, day and out-patient treatment center available year round for severely emotionally disturbed and learning disabled children between the ages of 5 and 15. An on-campus therapy educational facility provides special education programming 11 months per year (September through July), recreational and other adjunctive therapy, individual and group psycho-therapy, and parent education and therapy for the parents of the children.

Applications are accepted from Family and Child Care agencies, Child Guidance Clinics, physicians, mental health practitioners, schools, courts and parents. The application material should include a social history, psychological testing, school reports and medical information.

A trained, experienced child care staff (one for every seven to eight children) counsels the child in day-to-day living experiences and provides the child care and parental guidance needed for a healthy child-adult relationship. Social workers provide individual therapy help to the child and his family, work with groups of children and/or parents in group therapy sessions, and act as resource persons to the child care staff. A special education teacher, a teacher-aide and volunteer tutors (for each classroom unit of seven to nine children) provide individual prescriptive educational help. Recreation and program staff along with many volunteers help the child experience success in doing at least one thing well, thus breaking the patterns of defeat. A psychiatrist, psychologist, educational specialist, and a pediatrician are available. The staff, with referral agency and community representatives, meet for weekly conferences where each child is discussed at least once every three months.

The primary target population served by Edgewood are residents of the St. Louis metropolitan area. In 1976 residential treatment costs for children was $32.30 per day per child. Edgewood is a member agency of the Greater St. Louis United Way. An allocation of approximately 33% of the cost of operations in 1976 provided some subsidy to families referring children directly for treatment placement. Fees to public agencies for residential or day treatment are charged at the full cost of the service.

Project: EDUCATION IN LIVING

Director: Reba Jones, Psychology Department

Mailing Address: Fort Worth Independent School District, 3210 W. Lancaster, Fort Worth, TX 76107

Phone Number: (817) 737-3271

Project Description:

Education in Living is a semi-residential treatment program for emotionally disturbed children, ages 6 through 14 years, located on a 3,000 acre ranch with many natural resources—a lake, devil's den cave, trees, deer, longhorn cattle, etc.

Students are in residence from Monday morning through Friday for 180 days each year. The mornings are spent on individualized academics. The afternoon academics are related but less structured. Hiking, canoeing, horseback riding, gardening, and swimming are optional activities.

The program stresses developing decision making, self-reliance, self-control, and improved self-image. Etiology is not considered relevant. Individualized goals are developed with the participation of the student. Students also participate in making behavior rules at the camp.

Reinforcement, Glasser's Reality Therapy, and Maultsby's self-counseling are among the theories utilized.

Parent participation is encouraged through feedback communication of weekend behaviors, visits to the ranch, and bi-monthly meetings for parents in town.

The student's attendance and progress is reported weekly to their home schools by the social worker. The average stay for students is 50 days.

Regular teachers are invited to spend two days and one night in the program on a rotating basis. A followup six-week report from the teacher is made as to the utilization of techniques they have learned in their regular classes and the effectiveness of the technique tried.

The program costs on the average $2,000 per student. Support is provided by federal, state, and local funds, and a foundation.

Process and product evaluations by outside consultants have been very positive. Parents, teachers, and principals have praised the children's progress through letters to the director, psychologist/coordinator, and social worker.

Project: ERC PROJECT

Director: Diane Berreth Warrick

Mailing Address: 101 North Grape Street, Medford, OR 97501

Phone Number: (503) 779-5510, ext. 222

Project Description:

The Educational Resource Centers (ERC) program in Jackson County is designed for students who need special services to learn most efficiently. This includes students who are typically described as:

1. Emotionally Handicapped
2. Educable Mentally Retarded
3. Learning Disabled
4. Physically Handicapped

An Educational Resource Center is a place where a student goes for specific periods of time, usually on a regular schedule. The center provides academic and/or social skills instruction in order to continue and increase a student's enrollment in a regular class. Instruction may be provided directly to the student or indirectly through consultation with the student's teacher. The center's services also include program preparation and diagnostic testing. Each center is staffed by a resource teacher and a full-time assistant. The teacher must be state certified to instruct students with special needs.

The program is based on the philosophy that the most effective and humanistic approach to the education of children with specific needs is to teach each student according to his/her specific needs. The student strengths and weaknesses are determined by a careful analysis of his/her skills and deficits. These skills and deficits, both academic and social, are specified in terms of student behaviors to give the teacher direction on planning for the student.

Students are accepted for ERC programming after referral by parents, school, or social service agencies. The referral states the present concerns and terminal objective(s). The program measures current behavior and develops an instructional sequence to meet the objective(s). When the specified objectives are met, the ERC discontinues programming and provides followup service to the referring party as necessary.

Important components of the program include:

1. Mainstreaming—Each student in the program is enrolled in some regular classes within the building. The student participates in as many regular class activities as possible.
2. Behavior analysis—Each student's current performance is analyzed by identifying the frequency of specific behaviors. Consequences which increase and decrease those behaviors are determined.
3. Servicing across handicapping areas—With the behavioral approach, each student is regarded as an individual and not labeled according to his handicap.
4. Individualized instruction—The program for each student is based on his/her own skill deficits and learning rates.
5. Prescriptive programming—A procedural and sequential plan, based on behavioral objectives, is established for teaching each student a needed skill.

6. Daily monitoring of academic and behavioral progress—Decisions about each student are based on his/her daily performance data.

Project: GREEN BAY'S COOPERATIVE APPROACH FOR PROGRAMMING FOR EMOTIONALLY DISTURBED CHILDREN

Director: Richard Herlache, Supervisor of Special Education ED/LD

Mailing Address: Green Bay Area Public Schools, 525 S. Madison, Green Bay, WI 54301

Phone Number: (414) 497-3970

Project Description:

The program operated by the Green Bay Area public schools at the local Mental Health Center has been in operation for five years and is an extension of the local program for emotionally disturbed children. This joint effort by a community resource and a public school system is a unique and effective approach to providing services for emotionally disturbed children. The program has been effective in increasing the range of choices open to professionals working with exceptional children and provides an environment conducive to good mental health. The main task of the educational program at the Center has been to discover the methods and materials which will enable students to master academic materials and develop the behavioral controls appropriate to the social systems with which s/he comes in contact.

The program was developed in conjunction with Mental Health Center staff, State Department of Health and Social Services, and the state consultant for the Programs for the Emotionally Disturbed. Many planning sessions were necessary to arrive at a smooth running, effective program. The salient features of the program as it exists at this time are:

1. The Green Bay public school system provides the services of a diagnostic teacher and classroom teachers. We currently function with a staff of three classroom teachers and one diagnostic teacher.
2. The public school system provides the necessary instructional and non-instructional materials and equipment.
3. The Mental Health Center provides the classroom space and utilities.
4. The programming alternatives mutually agreed upon are:
   a. A child may live at home and attend classes at the Mental Health Center.
   b. A child may live at home, and attend classes, plus receive the services of the Center on an extended day basis.
   c. A child may live at the Center and attend outside education—regular or special education classes.
   d. A child may live at the Center and receive all services available, including school.
5. Each child referred to the Mental Health Center for possible admission receives a full evaluation including social work, psychiatric, psychological, medical, and educational evaluations. The information secured during the evaluation is used to determine appropriate placement at the Center, and if the child is placed, to develop a comprehensive plan of services.
6. Through ongoing evaluation, the total program is adjusted to meet the changing needs of the child. As the child improves and demonstrates an ability to be more independent, as determined by the reports of the various disciplines, a discharge plan is formulated. Before the final discharge is made, the diagnostic teacher does the liaison work with the receiving school. The diagnostic teacher sets up a feedback program to follow the student until a satisfactory adjustment is made.
7. The classes are structured to provide an educational environment conducive to improving mental health. This is accomplished by developing an individualized educational program for each child and includes appropriate supplies, teaching materials, equipment, and a controlled class placement. A written initial educational evaluation is completed on each child and after enrollment in the program, regular monitoring reports are maintained. When a student leaves the program, a final summary is completed which includes recommendations to meet the academic and behavioral needs of the child.

The main ingredient of a program of this nature, if it is to be successful, is cooperation—the cooperation of the Mental Health Center staff and the local public school system. Each must be committed to such an approach and see value in what the other has to offer. A financial commitment must be made between the Center providing the physical surroundings and necessary supportive staff and the school system providing the necessary personnel and instructional and non-instructional items. An evaluation and monitoring system must be built into the program. The evaluation should include evaluation of the environment, evaluation of the learner, evaluation of learning, and evaluation of instructions. These evaluations should provide for revisions and growth of the program.

Project: JORDAN RESOURCE CENTER

Director: K. Richard Young, Ph.D.

Mailing Address: 433 East Center Street, Midvale, UT 84047

Phone Number: (801) 255-5611

Project Description:

The Jordan Resource Center was established in 1972 as an alternative program for severely handicapped students living in the Jordan School District. It was designed to provide intense academic and behavioral remediation for students with severe handicaps and to support regular education's mainstreaming efforts in the neighborhood schools. The Jordan Resource Center assumes responsibility in four major areas:

1. The first and most important responsibility is to provide service to seriously emotionally disturbed students.
2. The second responsibility is to establish and conduct in-service training programs for teachers working with emotionally handicapped students.
3. The third responsibility is to develop and evaluate special education curriculum for emotionally handicapped students.
4. The fourth responsibility is to conduct research which will aid in updating and improving our educational programs.

These objectives are achieved through an empirically oriented behavior analysis approach to education.

The staff at the Center is comprised of a director and teachers certified to work with severely handicapped students. They all have in common extensive training and background in behavior management techniques including skills in data collection, task analysis, contracting, reinforcement, extinction, shaping, fading, and generalizing behaviors. Assigned to work with the teachers are para-professionals called behavior specialists. These people are trained by the Center staff in the use of behavior modification, diagnosis, prescription of learning problems, and tutoring techniques. Additional staff members include fulltime consultants responsible for parent-training programs, student transition and fading programs, and additional program development and crisis intervention. Support staff members to the Resource Center include counselors, social workers, a school nurse, and a school psychologist.

It is imperative in the multimodal approach to the treatment of handicapped children that all deficits are programmed. Eventually all of the deficits must be worked into the program in order to produce a lasting treatment effect thereby increasing the probabilities of a fuller life for these children. Therefore, the assessment, treatment, and prescription programs in a multimodal framework must include all related services necessary to complete the total program. In our setting we utilize backup resources from medicine, physical therapy, occupational therapy, and social services (individual and group counseling). These professionals work together in a team approach to provide the service essential for satisfactory and successful educational and training services for seriously emotionally handicapped students. As part of our multimodal approach, the Resource Center has developed three programs under the category of parent-education and training programs: (1) Parent Behavioral Management Class, (2) Parent-Child Communications Class, and (3) Parent Tutoring Programs. Three types of therapeutic programs are also offered: (1) Family Therapy, (2) Individual Therapy, and (3) Group Therapy. The combination of these therapeutic programs with the parent training programs provides a comprehensive system to support the Center's school activities.

Project: LAFAYETTE PROGRAM FOR ED/LD STUDENTS

Director: Paul F. Lane

Mailing Address: Ninth and Brown Streets, Lafayette, IN 47904

Phone Number: (317) 724-4830

Project Description:

The 1967-77 school year for the Learning Center was begun on September 1, 1976, with five students being admitted into the program. Four of these were new referrals and one was carried over from the previous term. By October 1, several new referrals had been received and nine students are currently being served. Additional enrollment for the remainder of this school year is projected at between five and eight.

Those children who have been reintegrated into existing public school programs through followup services are considered to be making successful adjustments. The demand for followup consultative services concerning students having been returned to their school during the 1975-76 school year has been limited to one student.

There have been numerous other direct services performed by the collective Learning Center-Clinic team during the 1976-77 school year. A necessary part of the total delivery system lies in coordinating with the regular school staff who refer children to and/or receive children from the Learning Center program. The collection of pertinent data prior to the child's enrollment and a comprehensive academic and behavioral prescription upon each child's reintegration into the regular school have been primary in effecting appropriate followthrough. School personnel involved typically visit the Learning Center during the treatment phase and shortly before reintegration to observe the child and to confer with Learning Center and Clinic personnel. Parents, while seeing Clinic staff on a regular basis as part of the total treatment program, are urged to do the same. The majority of parents visit and observe three or four times during the child's enrollment, although the number of visits varies considerably between parents. Each parent visits the program prior to their child's enrollment.

Video tape recording equipment made available through the State Department of Public Instruction has been very useful in the total treatment program. With some 16 hours of taping logged from early December to date (March 1977), the recordings have been used for numerous training purposes such as:

- for parents:
  - demonstrating cause and effect patterns of child behavior
  - teaching techniques of behavior management
  - demonstrating the teaching of appropriate social skills to the child
  - comparing the child's school behavior with home behavior
  - demonstrating progress in the child's control of his/her own behavior
  - in one case, comparing the behavioral characteristics of one child with those of another child
- for children:
  - demonstrating inappropriate behaviors by having the child view himself
  - teaching desirable social skills
  - aiding in a desensistization project for a phobic reaction to dogs
  - demonstrating progress in behavior control
- for Clinic staff and school personnel:
  - utilizing staffing sessions to seek opinions concerning child behavior
  - assisting in training graduate students who are conducting a social skills group within the Clinic
  - demonstrating appropriate behavior management techniques

Consultation and Education services have been made available to local mental health and education professionals and other professional and civic groups. Numerous individuals and groups have become oriented to the program itself and its philosophy through visiting the Learning Center and talking with school and clinic personnel.

Pamphlets have been prepared which provide a general description of the Learning Center program. These pamphlets have been mailed to interested parties and shared during visitations to the Center.

Project: **MINNEAPOLIS PUBLIC SCHOOLS PROGRAMS FOR STUDENTS WITH SERIOUS ADJUSTMENT PROBLEMS**

Director: Mr. Sheldon Braaten

Mailing Address: 1509 5th Ave., South, Minneapolis, MN 55404

Phone Number: (612) 333-1243

Project Description:

The purpose of the Clinton Junior High School Program is to aid individual students to develop sufficient coping skills and self-based behavioral controls so they can return to mainstream programs as quickly as possible.

The primary treatment approach focuses on managing the conditions under which the student attends school. A general school behavior monitoring and reinforcement plan, including the use of contracts, an overall point system, and tangible reinforcers, has been established in order to more consistently sustain staff and student expectations over the entire school. This approach generates data on student behaviors which can be used as information for a variety of complementary therapeutic interventions, including individual counseling, family counseling, and peer group therapy. It permits systematic targeting of specific student behaviors over all school environments, including the hallways, gymnasium, etc. It sets up the standards for access to reinforcers. It identifies and monitors those learning behaviors most necessary for successful functioning in a typical junior high school setting.

This approach takes into account each student's emotional makeup, social skills, and academic achievement levels. It identifies and coordinates community and family resources to permit the process of growth to occur as efficiently as possible. This approach identifies unique characteristics and special resources of the student's regular school when planning appropriate interventions and, ultimately, successful reentry into that mainstream program. Such an approach is, of necessity, interdisciplinary and ecological in nature, addressing the student's adaptation to his potential school environment.

A homeroom environment (initially, self contained) is the basic unit for beginning the process of turnaround for each student. Each environment contains the resources needed to address a wide range of academic skills and student interests. Each environment has a team of primary care staff, consisting of a teacher, instructional aides, and a support staff member, and has a maximum capacity of ten students. As individual students demonstrate an ability to be successful in their homeroom environment, additional resource areas in the school are developed and movement of such students into the new resource areas begins. The overall school program is conceptualized as one intended to be viewed by the students as initially very tight, but ever expanding as they demonstrate an ability to make successful choices and manage their behavior. Initially the number of staff and peers an individual child must react with is relatively small, permitting systematic interventions until serious problems diminish. As the available overall school environment expands, the students are required to successfully interact with an ever increasing number of staff and peers. Such an expansion of program permits an ordered progressing toward an approximation of a typical junior high school. It can eventually include extended field trips and participation in other stimulating activities away from school.

The Operational Goals are:

1. To increase the opportunities for each student to have successful social interactions with peers and adults in the school environment.
2. To increase each student's asserted confidence with regard to his own competencies in social and academic achievement areas.
3. To assure as safe as possible an environment in which the students can work and learn.
4. To reduce the frequency of maladaptive behaviors, particularly assaultive/combative behaviors, and promote the practice of alternative responses to such situations; thereby, increasing the frequency of positive adaptive behaviors.
5. To develop an ongoing diagnostic evaluative process which: a) clearly describes target behaviors and entering achievement levels; b) plans and prescribes intervention techniques; c) provides comprehensive feedback to each student on his progress; and d) measures growth and progress in behavioral terms for each student and for the general population.
6. To increase the number of positive responding behaviors individual students are able to make in any given situation.

This is a multi-faceted program. The program consists of the following components:

1. Five small environments which are carefully structured to meet the special needs of this population. Each environment will have: a) individualized programming; b) small group activities; c) precision teaching in the basic skills; d) group discussion that focuses upon concrete issues that assist the students to utilize communications instead of acting out behaviors to cope with their frustrations; 3) and a token economy which reinforces both adaptive and task behaviors.

   Each environment has a team consisting of an SLEP teacher, two child development technicians and a social worker. Academics and non-academics are taught in these basic environments.
2. Individual, small group, and family counseling services are provided to each student and his/her family upon a need basis. As it pertains to family counseling, this is contingent upon both the need and the willingness of the families to participate.
3. The entire school program is based upon a team concept. If this program is going to adequately respond to the needs of these students, all staff members must be consistent in their approach to the students. The only satisfactory method of achieving this goal is if each staff member: a) knows the program plan for each student and b) carries out that plan precisely by applying those agreed upon therapeutic techniques when dealing with that student, even though each staff person's style may be different.

   The following meetings and recording systems have been established to help guarantee that the school functions as a single unit: a) mini team meetings; b) daily school meetings; c) entry staffings; d) progress staffings; e) reentry staffings; f) group logs for each environment; g) a daily school communication log; h) progress notes in each student case file; and i) charting on targeted behaviors for individual students.
4. As students develop better internal control, i.e., integrate adaptive behaviors which serve them well under stress, they are moved into larger environments. These environments, while structured and well staffed, will more closely approximate regular classrooms. These approximation classrooms will: a) assist students in coping with increased classroom stimulus while still in a protective environment that assures the student will not be overwhelmed with anxiety that could lead to the reoccurrence of maladaptive behaviors before s/he has fully integrated her/his adaptive way of mastering problems, and b) provides her/him with a logical and systematic way to reenter mainstream education. Academics and non-academics are taught in the approximation environments.
5. The reentry of a student to mainstream education is a critical phase in the student's readjustment. Clinton staff work with receiving school personnel to plan creatively for appropriate transition and reentry experiences for the student. Options might include staff from the Clinton program phasing back with the student for a period of time, part-time placements, etc.

The staff complement includes:

1. project coordinator
2. five S.L.B.P. teachers
3. three graduate trained social workers
4. one graduate trained certified psychologist
5. twelve (12) child development technicians

It is intended that the program will not expand beyond the fifty (50)-student capacity initially planned for. However, through carefully and thoroughly assessing the needs of each student prior to entry into the program and then providing her/him with the best possible educational, therapeutic service, it is anticipated that students will move through the program and back into the community, thus continuing to be a resource for the Minneapolis School District.

Project: **NORTH DURHAM COUNTY RE-EDUCATION PROJECT**

Director: Suzanne M. Lamm

Mailing Address: 3132 Roxboro Road, Durham, NC 27704

Phone Number: (919) 477-7604

Project Description:

The North Durham County Re-Education Project, funded by Title VI-B, is operational as a continuum of services for emotionally handicapped children (children with learning and/or behavior problems) ages six through twelve. The continuum of services is in keeping with the concept "least restrictive alternative". Choosing the "least restrictive alternative" entails meeting a child's needs by keeping him as close as possible to mainstream society. The goal is to be able to return him to the regular classroom. A continuum screening committee acts on referrals to the continuum and makes recommendations as to the most appropriate placement for the child.

The following services are available:

1. Regular classroom
2. Teacher consultation
3. Mainstream Classroom—located at Bragtown School, class of 30, six of whom are identified as emotionally handicapped children
4. Resource Classroom—located at Bragtown School, class of eight identified as emotionally handicapped children, length of stay is six weeks
5. Day Program—located at Wright School
6. Residential Program—located at Wright School, units of eight identified as emotionally handicapped children, extended length of stay up to six months

Demonstration/Training Model for Public School Personnel

In addition to services for children, the North Durham County Re-Education Project functions as a demonstration model and as a laboratory for consultation and training for public school personnel working with emotionally handicapped children.

The following services are available upon request free of charge to schools, administrative units, or other public instruction and mental health groups:

1. Orientation to the continuum of services through visitation to Wright School and Bragtown School.
2. Short term training workshops (2-6 hours) to meet identified needs of participants dealing with topics such as:
   a. Behavior Management of the Emotionally Handicapped Child
   b. Life-Space Interviewing
   c. Limit Setting with Children
   d. Feelings and Behavior: Understanding the Relationship
   e. Characteristics of the Emotionally Handicapped Child
   f. Diagnostic Testing
   g. Role Playing
   h. Curriculum for the Emotionally Handicapped Child
   i. Developing Programs for Emotionally Handicapped Children
   j. Values Clarification
   k. Affective Curriculum
   l. Team Building
   m. Individual Plans for Children
3. Longer term consultation or training following the introductory workshop (perhaps a series of workshop/consultation sessions designed for the particular group requesting training).
4. Other learning aids such as films and mimeographed handouts are available through the project.

Project: **NORTH METRO CHILDREN'S CENTER**

Director: Dr. Arthur E. Bilyeu

Mailing Address: 846 Huff Road, N.W., Atlanta, GA 30318

Phone Number: (404) 352-3720

Project Description:

North Metro Children's Center

The North Metro Children's Center was established by the present Director in July 1974. The center was established as a part of Georgia's 24 psychoeducational center network. This network, funded by the Georgia State Legislature, is administered by the Georgia Department of Education. The function of the psycho-educational network is to provide community based services to children and their families who have severe emotional, and/or behavioral problems.

Organizationally the Center has five locations and is planning a sixth. These programs are housed for the most part in public school buildings which allow for maximizing opportunities for mainstreaming the children.

The cost per child served at the North Metro Children's Center is calculated on the basis of the total grant and state supplements divided by the contracted number of students to be served. This represents one-half of one percent of the total child population in the NMCC catchment area, or 528 children and families served in the course of a fiscal year. Per child costs for NMCC are $896, while the cost for the same child served in day treatment classes (211 children) is approximately $2,242 per year, a difference of $1,346 per child.

The Center serves four school districts, including Atlanta City Schools, North Fulton Schools, Gwinnett County and Buford City. The Gwinnett County Schools have been designated fiscal agent for North Metro. The superintendents of the school districts served by the NMCC comprise a Board of Control which has granted the director autonomy and latitude in the development of the program. An Advisory Board consisting of Special Education Directors, Mental Health Center representatives, parents and other agency personnel consult with the director and staff about issues and services.

The child served is between the ages of 0–14, and is defined as a child having severe emotional or behavioral problems at home, school and in the community. There are four types of children served by the Center in half or all day classes. These include the conduct disordered child who may be restless, attention seeking, prone to tantrums, hot tempered, and destructive; and the child with personality problems who is anxious, withdrawn, self-conscious, easily embarrased, feels inferior or is socially withdrawn, and is lacking in self-confidence. A third type of child is the inadequate, immature child who may have a short attention span, is lazy passive-aggressive, messy, and has a disorderly approach. The fourth child served would be the autistic, psychotic child who seems to prefer fantasy to reality, daydreams, lacks relativeness, repetitively uses objects and may demonstrate peculiar body motions, or unusual reactions to sound.

The Center staffing includes 15 state supported teachers and a similar number of assistants, two psychologists, a program evaluator, four social workers, an instructional coordinator, two office personnel, and a director. In addition, two federally funded demonstration projects have been established.

The services provided at the North Metro Children's Center include diagnostic services, incorporating psychological, educational, and psychiatric, as well as social services. The Center has attempted to incorporate non-traditional assessment procedures, i.e., structured parent/child video-taped sessions which seek to identify trends in parent/child interactions and attempt to incorporate the findings into a written home management program. Parent and family services are an integral part of the North Metro Program.

Psycho-educational classes are offered on a half or full day basis, four and a half days per week for children 3 thru 14 years of age. Consultation and follow-up services are provided to schools, agencies and teacher of students who are currently being served by the North Metro Children's Center. Day treatment classes focus on language development, socialization, and fine and gross motor skills as well as academic skills. Music and art therapy activities are designed for each child served in classes.

The Infant Program provides diagnostic and support services for infants and their parents in a primarily home based program to teach parents to interact more effectively with their developmentally delayed, motorically or sensorally impaired or physically handicapped children. A toy lending library has been established in the infant program. This component serves children from birth up through 36 months.

The staff for the Infant Program consists of two parent workers, 1/2 time family coordinator, one secretary, one physical therapist and a project coordinator.

There is no cost of services for families served as the program is state funded by the Georgia State Department of Education. Referrals are made by agencies and/or parents; however, in all cases no direct services can be provided until the parent has signed an initial request for service. When a parent makes referral, the appropriate school officials are informed and due process is implemented.

Philosophically, North Metro Children's Center utilizes a behavioral technology with a full range of humanistic as well as behavioral and more traditional intervention procedures, including individual, as well as group and family therapy. The Center staff have developed a structured observation procedure for providing the center treatment staff with feedback on staff-child interactions as well as providing other agency personnel with similar objective information concerning adult/child interactions.

Parent services are emphasized and the Karnes family involvement model has been adapted for parent services; a written home management program has been developed for each child in the center's program, with stated goals for measurable objectives, which are evaluated weekly. A team approach has been established which requires a psychologist and social worker to review home treatment and school and center objectives.

The Center operates a 12 month program, with the summer program focusing on socialization, recreation, and fine and gross motor and language development.

A computerized management information system has been developed which provides information on the status of children in terms of intake as well as follow-up and consultation procedures.

The Center has also received a three year demonstration program for families and children who are delayed developmentally or have physical as well as behavioral or emotional disabilities. The services offered include: developmental evaluation of the child, assessment of family needs, development of individualized programs for the child focusing on language, and motor cognitive, social and self-help skills. Parent focused home visits are designed to teach parents how to implement the intervention program. Parent groups, workshops and other activities for support and educating family members are designed to assist parents in advocating for their own child. A library of toys and materials has been developed for use by the families and consultation and coordination with community agencies is also a part of the infant demonstration project. A classroom with parent involvement is projected for the late Spring of 1977.

Project: **PROJECT SPEED**

Director: Elizabeth B. Blanck

Mailing Address: Special Services Office, Anna Boyd School, 900 Brookmont Lane, Columbia, SC 29203

Phone Number: (803) 786-5650

Project Description:

Project Speed, a special program emphasizing educational development for emotionally disturbed secondary students, basically follows a self-contained model. Following referral by teachers and/or administrators, permission for testing is secured from the child's parents or guardians. Subsequently, the child is tested and clinically screened by the school psychologist. If he meets the state guidelines for the EH child and appears appropriate for the program, his parents, teachers, administrators and the school psychologist convene for a placement meeting. He is then placed in the self-contained Speed classroom where he will remain throughout the day for a minimum of six weeks before he is allowed to begin working his way out into a regular class or two during the day. When the student is able to return to and remain in all his regular classes, the process is considered successful and the school psychologist executes formal termination procedures for that child.

Goals of the project are:

1. Increased academic achievement
2. Decreased absenteeism, suspension and expulsion rates
3. Significantly improved responsible student behavior
4. A supportive academic environment
5. Demonstration classrooms for teachers and administrators
6. Workshop programs for teacher training
7. A mini-parent training course
8. A manual of therapeutic teaching strategies

In order to devise a theoretically sound, pragmatic plan which would serve as a framework for implementing techniques leading to our goals, it was necessary to consider the following topics:

1. *Kinds of Students*. The types of students referred to these programs are individuals who do not respond with improved behavior to the usual consequences (reprimands, lectures, paddlings, detention halls and suspensions) for disobedience, disrespect, and disruptiveness. Furthermore, many exhibit outrageous individualism and are adept in creating chaos within any structure. Approximately 93% of the referrals are males.
2. *Our Resources*. Our school district has one psychologist, one therapy coordinator, one curriculum coordinator, seven teachers and four aides for 6,000 secondary students in four secondary schools.
3. *Approaches That Appear Adaptable*
   A. Behavior Modification—Use of methods such as precise identification of behavior to be changed, contingencies, contracts, and highly structured classroom.
   B. Operant-Interpersonal—Mediation of the teacher and/or therapist to encourage free expression, prevent loss of face and implement structure in the environment to improve the outcome. The teacher and therapist also facilitate communication and understanding of roles and objectives in teacher-student-administrator-family-other agency relationships.
   C. Glasser-Adler—Maximum use of classroom meetings, making plans, and contracting for change to increase respect, responsibility, relatedness and reality orientation. Specifications of causes of behavior according to Adlerian categories and employment of the appropriate techniques for each.
   D. Guidelines by William C. Morse
      1. Teachers are to teach, not be quasi-therapists. Teaching that increases achievement also increases self-respect and responsibility and is thereby therapeutic.
      2. No single therapeutic process exists, but all positive outcomes are therapeutic.
      3. The essentials for therapeutic teaching are: a high degree of structure, an individualized curriculum, flexibility of approach, and provocative topics; group interactions, experiences, solutions, and a dynamic classroom; records, extensive observations, collection of data and turning to interdisciplinary consultation when necessary.

Judo (Judicious Use of Dynamic Operations)

The Judo method is a general approach with variations for the different age levels. It is a method of interaction which is an excellent strategy for teachers of regular classrooms as well as for those of special education. The model employs specific techniques to encourage the student to increase his constructive skills and his control over himself and his environment. The role of the teacher is to move out of the center of control as student self control increases. The *Short Term Goal* of Judo is to move the student immediately from a high rate of maladaptive behavior to as much constructive behavior as he is capable of choosing.

Project: **PROJECT SPRING**

Director: Peyton Towns

Mailing Address: 892 Vadado Way, N.E., Atlanta, GA 30308

Phone Number: (404) 875-7704

Project Description:

A demonstration project serving seriously disturbed adolescents, 15-18 years of age, has been funded by the Georgia State Department of Education with Title VI-B funds, Project SPRING (Special People Realizing Individual New Goals). The project is housed at Grady High School in Atlanta and serves adolescents who demonstrate general fearfulness and anxiety, seem to prefer fantasy to reality, are subject to uncontrollable or irrational fears, and are potentially dangerous to themselves or to others. Some are consistently bizarre in speech or behavior. Most of these students have tried many different programs, including residential programs, and have not responded. The project attempts to serve primarily seriously emotionally disturbed children and is not designed to serve the socially maladjusted student whose primary deficit is in terms of relationship to authority figures. Project SPRING provides a center based program in the high school as well as outreach programs for those who are unable to conform to the structure required in a high school. A survivals skill curriculum has been developed and a vocational habilitation curriculum is being developed. The services include diagnostic, psychological, educational, psychiatric, pre-vocation assessment and counseling. Day classes include academic instruction, group as well as individual, and family counseling. The outreach services are primarily for those students unwilling or unable to attend the center and include on-site tutoring, counseling, and vocational services. There is no charge for services as the project is a federally funded state demonstration project. This project is family focused and family involvement oriented. 75 students will be served in the project.

Project SPRING is staffed by one social worker, one vocational rehabilitation teacher, one educational coordinator, four educational assistants, 1/2 time psychologist, one secretary and a project coordinator.

Project: **SBD PROJECT**

Director: Dr. George J. Yard

Mailing Address: Hubert Wheeler State School, 5707 Wilson Avenue, St. Louis, MO 63110

Phone Number: (314) 645-4752

Project Description:

The S.B.D. Project which began December 1, 1974 is currently in its third year of operation. The grant is through the University of Missouri-St. Louis and has been funded, for the most part, with Title 6, Part D monies.

The grant is designed to train teachers from Missouri's State Schools for the Severely Handicapped to work with children who are severely behaviorally disordered or have autistic-like characteristics. Three week training sessions are offered to the teachers with the training conducted at the Hubert Wheeler State School in St. Louis, Missouri.

The project target audience has been youngsters between the ages of 5 and 12. Generally, these youngsters exhibit several of the following characteristics: severe communication problems, lack of eye contact, withdrawal tendencies, resistance to change, perseverative movements such as rocking, spinning, finger posturing, etc. Generally, the children are attractive in appearance and many may be hyperactive and/or self-abusive.

The project staff developed the training program to encompass identification and delivery services to the severely behaviorally disordered. The project staff works cooperatively with the staff of the State Schools for the Severely Handicapped in the training and supervision of the S.B.D. teachers. Once a teacher is trained, she returns to her home school and sets up an S.B.D. class which is composed of no more than five students. Members of both staffs then offer support services to the trained teachers. Similar consultative services are provided to teachers of the severely handicapped who wish help in managing the behavior of their students.

24 teachers have been trained to date, and 12 S.B.D. classes are currently in operation in Missouri's State Schools for the Severely Handicapped.

Project: **ST. PAUL PROGRAMS FOR SOCIAL DEVELOPMENT (PSD)**

Director: Morris Shrago

Mailing Address: 60 South Ruth Street, St. Paul, MN 55119

Phone Number: (612) 735-7215

Project Description:

The St. Paul Programs for Social Development (PSD) provides an educational environment for autistic and autistic-like students and students with serious emotional and behavioral problems. PSD is available to preschool through high school students (2-21 years) who live in St. Paul or in school districts participating in the East Metropolitan Special Educational Council (EMSEC). Funding is provided by the St. Paul public schools and state-administered Title VI-B funds.

Children and youth in the St. Paul public schools are referred to PSD by their home school principal and local

Child Study Team. Referrals from other EMSEC school districts are made by local directors of Special Education. Parents may request admission for their child, and teachers, social workers and other agency representatives may refer students with parental consent. Permission to enroll in the program is obtained through the local Director of Special Education. Both program and transportation are free to parents.

All requests for admission are made to the program social worker who with the parents, referring agency and PSD staff review evaluations and information to determine whether the program is an appropriate placement.

The students attend five days per week from 9:00-3:30. Group size varies from five to eight children. The areas of emphasis are behavioral controls, academics, communication, socialization, practical living, and pre-vocational and vocational skills.

The developmental and behavior modification approach used in the program guides the child in learning to respond to and trust the environment, in learning individual skills, and in learning to apply these skills within groups and in a variety of settings.

The staff consists of certified special education teachers, educational assistants, a psychologist, social worker, parent educator, occupational therapist, speech and language pathologist, and an adaptive physical education teacher.

A consultant is available in the area of medicine and psychiatry and a range of services are available through the Child Study Center of the St. Paul schools.

Continuing staff training and inservice workshops are held to strengthen the skills of the staff needed in working with students.

The parent educator and social worker provide coordination with the student's parents, their home schools, and agencies serving them.

The program provides parent involvement through home training, parent groups and parent counseling. Parents are encouraged to observe their children often in the classroom through special viewing windows. This enables both parents and staff to develop greater insight into the child's specific problems and helps the parents learn to use materials and management techniques for dealing more effectively with their children.

Project: **SCHOOL WITHIN A SCHOOL PROGRAM**

Director: W. David McEchron, School Psychologist/ Project Coordinator

Mailing Address: School Within A School, Central High School, 1120 Main, Davenport, IA 52801

Phone Number: (319) 323-9951 or (319) 391-0400

Project Description:

The School Within A School (SWS) Program at Central High School is a Title IVc project in its first year of funding designed to foster emotional adjustment and reduce the dropout rate in a large inner-city high school.

Approximately 1/2 of the school students are high risk dropouts or are returning to school after having dropped out. Their primary problems are attendance, attitude toward school and authority, and work behaviors. They also tend to manifest delinquent and antisocial behaviors as demonstrated on behavior rating scales and objective psychometrics.

The other 1/2 of the SWS students are seriously emotionally disabled (ED) students. Their problems tend to resemble clinic and residential patients. The ED students receive complete psychological evaluations and staffings are held where individual academic and treatment goals are determined. Program staff are responsible for both academics and therapy.

The program has the capacity for servicing 50 students, all of whom attend a three hour block of core courses in the morning. The morning SWS program consists of language arts, math, and social studies. Special activities such as field trips and guest speakers are held at least once a week. The morning academic program is presented on a unit basis with no text books, homework, or fixed time schedule. A team teaching approach is used where each of the academic subjects is taught by a team of a regular education teacher and a certified teacher for the emotionally disabled. ED and non ED students are mixed together. A variety of therapeutic approaches and activities are used for ED and non ED students.

After the core program, students are scheduled into regular academic and vocational classes, work experience, remedial classes, and/or classes for the emotionally disabled.

Other personnel connected with the program are a full time School Psychologist and a full time School Social Worker who provide ongoing contact with the students and their families and participate in program planning and administration.

The goals of the program are to:

1. Lower the dropout rate
2. Improve grade point average
3. Increase the rate of class attendance
4. Increase the rate of credits being earned toward graduation
5. Improve self-concept
6. Improve social behavior
7. Reintegrate the students back into mainstream education programs

All program goals are objectively measured. Data received to date indicate significant progress is being made toward accomplishment of goals. The SWS program has many components which appear to be exportable to other secondary school settings.

Project: THE CENTRAL KENTUCKY RE-ED PROGRAM

Director: Lorraine Krsetch

Mailing Address: 690 Newtown Pike, Lexington, KY 40508

Phone Number: (606) 253-2436

Project Description:

The Re-Education Program for Children provides preventive and rehabilitative mental health services for children with emotional, social or behavioral problems in the Central Kentucky Region. The program works primarily through existing agencies by providing a broad continuum of services ranging from professional support to families and teachers to short-term residential placement for those children who cannot be maintained in the local community.

The approach is based on Project Re-ED (Re-Education of the emotionally disturbed child) which has established a record of 17 years of success in dealing with the problems of behaviorally disordered children in Tennessee and North Carolina. In the Bluegrass Region of Kentucky, estimates of the number of children with emotional and behavioral problems needing special attention range between 9,000 and 13,000. Sponsors of the Re-ED program in Kentucky believe that a large percentage of children with emotional problems are best served by a comprehensive program offering supportive and intervention services within the child's normal environment supplemented by a residential program for the child when needed, with counseling for the child's family and consultation with the child's community agencies and school.

Since 1971, the Re-ED program in the Central Kentucky Region has developed a residential unit for 32 children for six months or at least 64 children per year, with a network of ten community liaison educational counselors who serve approximately 600 children per year. These counselors function as the intervention and prevention agents for children referred who are experiencing emotional or social problems which impede development or progress. In addition, the counselors are the referral sources for children needing a residential placement in addition to the followup community services.

The Re-ED School is a short-term residential program which becomes a part of the child's ecological system for only as long as it is needed. The child participates in the residential program from Sunday evening to Friday noon, during which time he is involved in intensive relearning experiences, including the realities of an academic school program and living with a group of seven other children. One night and two day counselors, together with a liaison counselor, are responsible for each group of eight children. The liaison counselor serves as a link between the residential program and the important social agents in the child's home community.

Although the child is in a residential program for most of the week, his family, his school and local community agencies still maintain responsibility for him. The liaison counselor works with all of these units, attempting to strengthen them to the point where they can support the child without Re-ED. Specifically, the parents are enrolled in a parent management and communication course where they learn principles and techniques of behavior management (the parents like their children, are not treated as if they were "sick"; that is, greater emphasis is placed on weaknesses and deficits). Moreover, the child goes home every weekend so that the family unit is preserved with the child as a part. The liaison counselor also works with school personnel to develop strategies for returning and maintaining the child in school. Community agencies, such as churches, Boy Scout groups, etc., are mobilized to help support the child's return and maintenance.

Project: THE LEARNING PLACE

Director: Peter Knoblock

Mailing Address: 601 Harrison Street, Syracuse, NY 13210

Phone Number: (315) 479-7744

Project Description:

Jowonio: The Learning Place is a therapeutic learning environment for severely emotionally disturbed children and typical children. Our school has 46 children, ages 3–9. 15 of the children are considered severely multiply-handicapped with emotional disturbance as their primary handicapping condition. By employing a ratio of 2:1 (typical children to handicapped children) we maximize many of the advantages of educating troubled children in an integrated environment, such as the possibility for increased social interaction, utilizing a developmental curriculum approach that is appropriate to each child's individual needs; and capitalizing on naturally occurring interactions between handicapped and non-handicapped.

However, successful integration requires more than physical proximity; it requires planned structuring of class groupings and schedules, providing opportunities for interaction curriculum activities, and social experiences.

The basic grouping in the school is the "family group", based on the format used in the British infant schools in which children of varying ages are placed together. In The Learning Place, typical and handicapped children are assigned at the beginning of the year to a family group (located in a particular room); each group, led by 3 consistent adults, consists of nine children, three of whom have been labelled disturbed. In addition, each group has an age spread of three or four years within it and as much as possible a balance of sexes. Thus, in each group there is a wide range of developmental levels among the typical children as well as the handicapped children.

Our teachers are very active in creating an environment which facilitates interaction through two major efforts: (a) the choice of activities and materials and (b) the attention paid to social-emotional concerns of all the children. In the family groups, materials made available and activities which are teacher-initiated reflect the need to accommodate a wide range of developmental levels in both typical and handicapped children. This may mean that the material or activity allows children to participate in different ways, with varying degrees of complexity; for example, blocks can be used to build very elaborate buildings or can be put end to end or stacked or used in sorting and matching exercises. Thus, an integrated group of children sitting around a table working with blocks can be working "independently together", can build on each other's work, can talk about what they're doing, offer feedback to others; teachers can interpret and reinforce, guiding not only the individual efforts but the interaction. In addition, teachers may initiate activities all the children enjoy, e.g., blowing bubbles, eating, singing games, paste, clay, paint, sand and water play. Opportunities are available for children to interact verbally and non-verbally, cooperatively, and to realize they can share interests and experiences. Lastly, teachers consciously set up activities which are joint and require several children to work together; the teacher may specifically ask some children to help others on particular tasks. Helping and teaching behavior is reinforced for all children.

The teachers at The Learning Place have a commitment to a therapeutic psycho-educational approach focusing on the feelings as well as the cognitive needs of all the children in the school. This occurs constantly in the thousands of interactions in a day; it is also structured in as a legitimate activity. Each family group meets daily for a discussion time; in one room this is called a "magic circle". The focus of the discussion is the feelings of individual children and adults or group interaction, and in these discussions, issues related to integration are raised.

Contrary to the myths that non-handicapped children will scapegoat handicapped children, we have found a great deal of caring and responsiveness. The non-handicapped children play in a parallel and cooperative manner with the labelled children. They also function in a teaching capacity. Parents of typical children all chose this school knowing its integrated nature. They have been very supportive of what we are trying to do, and have responded to their children's concerns and questions. Teachers have a crucial role in successful integration. Our teachers, by their words and behavior, demonstrate their respect and caring for each and every child in the school; children seem to feel themselves valued and can in turn respond to others; children model the teachers' words and behaviors with each other. Teachers offer explanations for behavior and suggest ways to deal with the behavior of others. They support growth of all children at all different levels.

Each child has a teacher who functions as an advocate. This adult has the primary responsibility for coordinating the range of support services available to the child and family. We have on our staff professionals in the area of social work, physical therapy, movement therapy, instructional technology, language therapy, and school psychology.

Our goal is to have special children return to public school programs as they become ready; and as schools develop appropriate programs.

Project: **THE RE-ED SCHOOL OF KENTUCKY**

Director: Donald R. Alwes, Sr.

Mailing Address: 1804 Bluegrass, Louisville, KY 40215

Phone Number: (502) 368-2591 or 368-2592

Project Description:

The Re-Ed concept emphasizes health, not illness; teaching, not treatment; unlearning negative behavior patterns while learning positive ones, not fundamental personality reorganization; the symptom, not the cause; and the total social system, not just the child. Re-Ed's specific objectives focus on diagnostic evaluation of referred children and effecting behavioral modification which will enable 70% of these students to function satisfactorily in regular classrooms.

The national validation study by the United States Office of Education found the educational model highly innovative. The model used in the project is based on the philosophy that inappropriate behavior is learned and, therefore, the child can be re-educated and learn appropriate behavior. Children learn to monitor their own behavior through the use of behavior modification techniques. A variety of professional and para-professional people work with the child and teach him to analyze his own behavior and that of his peers. During "pow-wow" sessions the child learns to express his feelings and problems, cope with his problems and make his own decisions concerning what his problems are and how to solve them. He learns how to successfully monitor his behavior not only in the Re-Ed setting, but also in his home environment and his future school and community environment.

In 1968, Title III ESEA provided the initial three year grant; and in July, 1969, a residential facility for 32 children was opened. Two months later, satellite classes (from 9:00 to 1:30 daily) were begun in regular schools.

The initial Title III grant was twice extended, ending July 30, 1973. Beginning July 1, 1973 the six school districts which had been served by the project joined with seven others and the Kentucky Department of Mental Health in Kentucky in financing the Re-Ed School and its satellite classes.

The residential school consists of one four-story classroom/living/administrative facility, including classrooms, sleeping rooms, kitchen, living area for night staff, recreational areas and offices. The satellite classes, however, are housed in three public schools of Jefferson County and teachers' salaries are paid through minimum foundation units.

The seven-county area supplies referrals on rural, suburban, urban, and inner-city children, ages 6 through 12, eligible for grades 1 through 6. Children are accepted for a four-month period, negotiable with the referring school district, the Kentucky Bureau for Health Services (River Region Services) and the Re-Ed staff at the end of this time. Satellite children are enrolled for six months because of the shorter classroom day. Referrals are made by the classroom teacher, principal, or counselor, but may be initiated by family, agencies or physicians. The referred child must possess average or above intellectual potential, manifesting behavior inappropriate for his age.

Since 1969, there have been approximately 750 referrals. Of these, about 450 have been enrolled in either residential or satellite classes. All but 56, our present enrollment, have been returned to their regular schools. Behavior has stabilized and is being maintained at an acceptable level in home, school, and community for most of these students. Although Re-Ed is a behavior modification school, not designed to upgrade a student's academic achievement, there has been progress in the basic skills for most of the children who have returned to their home schools. 86% of the students are behaving appropriately since Re-Ed termination.

The specialized staff of Re-Ed pre-evaluates, diagnoses, re-educates, post-evaluates, and conducts follow-up for two years on those children referred and accepted. Re-Ed also offers ancillary services to parents, schools, state universities and others. These services take the form of workshops, parent counseling groups, practicum or internship training, staff meetings in Region III schools, and demonstration programs. In addition to the above, the Re-Ed specialists will work with any child with behavioral problems at the request of the school system, either directly or through the child's teacher on a crisis intervention basis. Screening, placement, transition and follow-up services are a part of each accepted student's care.

Staff and Training

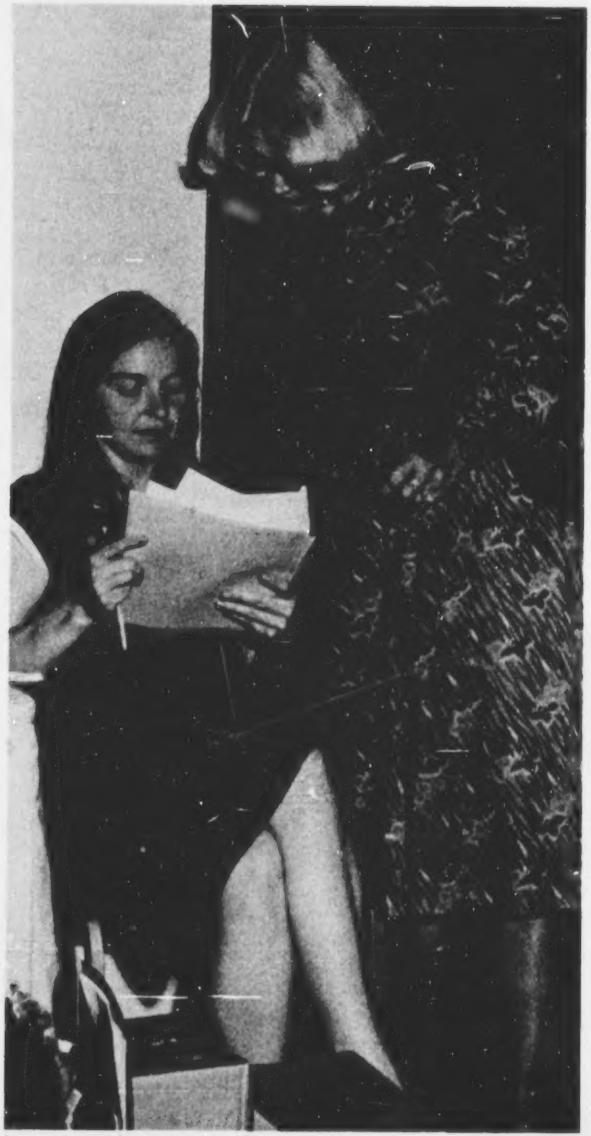
The Re-Ed staff members were selected by the Jefferson County Board of Education, then certified through an initial training program at the University of Louisville. The innovative pre-service program was designed and established by the School of Education at the University of Louisville for the express purpose of training the entire Re-Ed School professional staff in the methods and techniques to be used in the education of emotionally disturbed children to be served by the project. During the training period, the staff was trained to operate within the unique educational model designed for the program. For the original 16 members of the Re-Ed staff, professional pretraining at the University of Louisville for three months cost $59,579. Inservice training has continued at the beginning of each year (five days) for new members and for workshops, speakers, etc., and for returning and new staff. Also, our staff members have continued their professional training in the area of emotional disturbance or learning disabilities.

Parent Consultation

The parent counseling program is unique in its nature and extensiveness. Before children are placed into the Re-Ed program, the parents sign a contract to participate in scheduled counseling sessions with the staff or to continue in the counseling program in which they are already enrolled. In addition to the parent effectiveness training or other counseling with a community agency, the parents have weekly sessions with both the morning teacher and afternoon teacher working with their children. In the two weekly sessions the teachers counsel the parents in what to expect during the child's home visit, how to manage behavior problems at home to reinforce the behavior modification program.

Costs

During the planning year, costs involved staff development and professional personnel stipends. In the initial year of operation, expenditures covered equipment, materials, facility, remodeling, and professional and paraprofessional salaries. Average cost for 1970-71 and 1971-72 was $26,238 for equipment and supplies, $190,519 for professional salaries, and $66,307 for paraprofessional salaries. Vans, kitchen, audio-visual equipment, household-type furniture, and linens added to the expense of establishing a residential school. Also, many materials designed specifically for emotionally disturbed children are expensive, but much of this cost is offset by teacher-made materials to individualize eight children per group with perhaps as many grade levels. Since the beginning in 1968, Re-Ed has spent $182,305 for equipment and materials. All of these costs depend upon the area in which the facility is established—teacher salary range, facility costs, volunteer services available, labor rates for required remodeling and/or maintenance, payscale for para-professionals, and availability of services from local/state agencies at little or no cost. Each potential replicator of this project must assess per pupil cost data and learner outcomes in relation to the needs of their particular school district.



Appendix B

MATERIALS LIST

The following list of materials displayed at the conference was compiled to serve as a resource to program administrators as they assist teachers and related personnel responsible for providing educational programming services to emotionally handicapped children.

This listing is certainly not exhaustive but rather reflects many innovative and effective teaching devices, which together with the application of appropriate programming procedures found in this document, should enhance administrative efforts at both the SEA and LEA level for improved service delivery to children.

CONTRIBUTOR	MATERIALS
Allied Educational Council Dist. Center P.O. Box 75 Gaben, MI 49113	• *The Fitzhugh PLUS Program*, 1975, Allied Education Council. —9 individualized instruction books on perceptual training and language and number concepts with placement guide and teacher's manual
Allyn and Bacon, Inc. Longwood Department Rackleigh, NJ 07647	• *Teaching Children With Learning and Behavioral Problems*, 1975, Donald Hammill and Nettie Bartel, 306 pages. —reviews roles of teachers in management of children with school related problems, provides basic information regarding appropriate assessment techniques and instructional methods, lists specific materials, prices and sources
American Guidance Service, Inc. Publishers Building Circle Pines, MN 55014 (612) 786-4343 Contact: Mary Louise Juhnke	• DUSO Kit (Developing Understanding of Self and Others)—Instructional program designed to promote children's social and emotional development. D-1 (Kindergarten and Lower Primary) (Price: $115.00) • Brochures—DUSO • Brochures—TAD Program—"Toward Affective Development" (Price: $95)
Behavioral Publications Subsidiary of Human Sciences 72 5th Avenue New York, NY 10011	• "Titles of Interest in Special Education," Human Sciences Press, Behavioral Publications, Inc.
CORBEH 1590 Willamette Street Eugene, OR 97401 (503) 686-5311 Contact: Dr. Hill Walker	• Brochures—CORBEH—Center at Oregon for Research in the Behavioral Education of the Handicapped— • Behavior Management Packages —CLASS—Contingencies for Learning Academic and Social Skills —PASS—Program for Academic Survival Skills —PEERS—Program for Establishing Effective Relationship Skills* —RECESS—Reprogramming Contingencies for Effective Social Skills* • CORBEH Training Packages include the following: Training Packages (CORBEH) include the following: Consultant Materials Package—includes all charts, forms and schedules needed to carry out program Consultant Manual—describes a set of procedures for modifying the classroom behavior and demonstrates to the consultant how to train teachers and other social agents (parents, peers) to apply social learning principles— Manual for Consultant Trainer—for use by a consultant trainer, who acts in a supervisory capacity to a group of teacher-consultants who wish to receiving training in the implementation of the CORBEH Programs. Teacher Manual—specific procedures are detailed for use in the classroom to insure that the child will become a productive member of the regular classroom • CORBEH—Report #22 CLASS Field Test Evaluations —Report describing complete program

Prices shown where available.
*Completion date end of 1978.

CONTRIBUTOR	MATERIALS
Center for Educational Innovation 750 Brooksedge Blvd. Westerville, OH 43081 (614) 444-9780 Contact: Marnie Morrison	• SKILTRAC prototype manual for the 1977-78 system and materials • PLAN (Prescriptive Language Assessment Notebook), which will be adapted as the assessment portion of the Language curriculum • Paths: Instructional Techniques and Activities which is provided with with the instructional and activity components of SKILTRAC • Questions and Answers about SKILTRAC (information sheets) • CEI on IEP (pamphlets)
The Council for Exceptional Children 1920 Association Drive Reston, VA 22091 (202) 620-3660 Contact: Mary McCaffrey	• U.S. Office of Child Development Project on Child Abuse and Neglect Units 1-6 "Introduction to the Curriculum: The Identification Sequence" Units 7-12 "Community Response Sequence" Unit 15 "Specialized Training for Educators"
Fearon-Pitman Publishers, Inc. 6 Davis Drive Belmont, CA 94002 (415) 592-7810	• "Professional Resource Titles" —a brochure of recent publications—
Gateway School Autistic Project Administrator 4000 Silver Star Road Orlando, FL 32808 (305) 293-6252 Contact: Geraldine E. Brown	• "From Self-Stimulation to Pre-vocational Training—A Total Program for Autistic Children" Authors: Geraldine E. Brown Gene LaRoe Patricia Newman —includes programming considerations for the classroom teacher, behavior modification intervention model, visual, auditory, motor, behavioral, social, self-help, and language curriculum, scheduling and learning centers—(Price: $2.00)
Media Materials Inc. 2963 Remington Avenue Baltimore, Maryland 21211 (303) 235-1700 Contact: Burt Criste	• *Individualized Cassette Learning Package: 9101 Structural Analysis: Compound Words*, 1976, Media Materials Inc. —a kit containing a cassette, teacher's guide, student booklets and post test—
National Association for the Education of Young Children 1629 21st Street, N.W. Washington, DC 20009	• NAEYC-PUBLICATIONS—brochure of recent publications
National Clearinghouse for Mental Health Information (NIMH) 9000 Rockville Pike Bethesda, MD 20014 Contact: Sharlet Moore	• *Detection and Prevention of Learning Disorders*, 1976, 31 pages. • *The Mental Health of the Child: Program Reports of the National Institute of Mental Health*, 1971, 588 pages. • *Schizophrenia, Is there an Answer?* 1976, 16 pages. • *Mental Health at School*, 1973, 23 pages. • *An Annotated Bibliography on Mental Health in the Schools*, 1970-73, 1974, 29 pages. • *Children's Play and Social Speech*, 1975, 24 pages. • *An Annotated Bibliography, Violence at Home*, 1974, 96 pages.

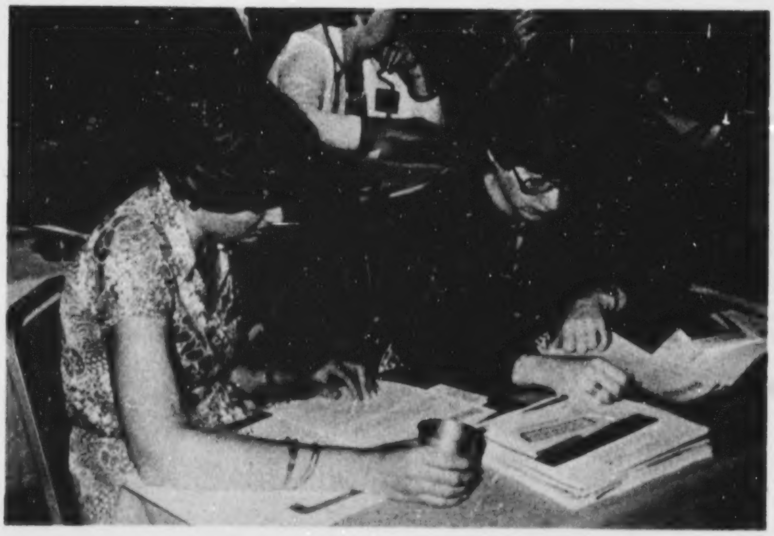
CONTRIBUTOR	MATERIALS
NIMH continued	• "Parents are People, Too . . ." 1975, 17 pages. • "Recreation for Autistic and Emotionally Disturbed Children", • "Trends in Mental Health: Treatment of Schizophrenia", 1975, 12 pages. • "Mental Health—Schools" —a selection of abstracts of mental health programs compiled by NIMH— (Complimentary copies available upon request from NIMH)
North Metro Children's Center 846 Huff Road, N.W. Atlanta, GA 30318 (404) 352-3720 Contact: Arthur E. Bilyeu, Director	• Brochures—"North Metro Children's Center" Serving the Seriously Emotionally Disturbed —describes the children's center, the child served by the center, the services provided and the cost of services— • Brochures—"Family and Infant Program" • S.P.R.I.N.G. "Special People Realizing Individual New Goals"
Ohio State Department of Education Division of Special Education 933 High Street Worthington, OH 43085 (614) 466-2650 Contact: Dr. John Saylor	• *Program Standards for Special Education* effective June 30, 1973 • *Standards for Due Process and Procedural Safeguards for Handicapped Children and Youth* effective August 28, 1976, Ohio Department of Education, 84 pages.
Plenum Publishing Corporation 227 West 17th Street New York, NY 10060	• Brochures of Publications dealing with the Emotionally Handicapped: *Helping Troubled Children*—Rutter (Price: $17.50) *Journal of Autism and Childhood Schizophrenia*—Schopler and Rutter (Price: Subscription: $38.00) *Journal of Abnormal Child Psychology*—Quay (Price: Subscription: $38.00) *Journal of Youth and Adolescence*—Offer and Adelson (Price: Subscription: $44.00)
Project Advocate 441 N. Farnsworth Aurora, IL 60505 Karen Ryan, Diane McConn	• "Decisions, Values, and Other Growing Skills"—Diane McConn • "Materials That Work"—Karen L. Ryan • Brochures—describing Project Advocate, a public special education program for students who exhibit behavior problems— • Index—Software (Project Advocate) —listing of materials available and cost—
Research Press Company 2612 North Mattis Avenue Champaign, IL 61820 (217) 352-3273 Contact: L. Drake	• "ALTERNATIVES", Research Press, 1977 • *How to Put up With Parents: A Guide for Teenagers*, 1975, Facilitation House, 126 pages. —a large part of the responsibility for making life go well is shifted away from the parents and placed on the shoulders of the teenagers themselves—(Price: $5.65)

CONTRIBUTOR	MATERIALS
Research Press Company continued	• *Child Management, A Program for Parents and Teachers*, 1976, 131 pages. —provides parents with a systematic point of view for interpreting behavior in order to create a healthy learning environment—(Price: $3.95) • *Systematic Parent Training, Procedures, Cases and Issues*, 1975, 164 pages. —intended for those utilizing social learning principles in intervening with families and children with disturbing behavior—(Price: $8.95) • *Developing Student Discipline and Motivation*, 1974, 68 pages. —a series for teacher in-service training presented in workshop format—(Price: $3.95) • *Issues in Evaluating Behavior Modification*, 1974, 264 pages. —proceedings of the first Drake Conference on Professional Issues in Behavior Analysis, 1974—(Price: $3.95)
Scholastic Book Services 909 Sylvia Avenue Englewood Cliffs, NJ 07677 Contact: Cheryl Johnson 5922 Eastern Avenue N.E. Washington, DC 20011 (202) 635-3818	• Scholastic Literature Unit "Personal Values" —builds on the adolescents' interest in discovering their own values and those of others by providing students with the opportunity to spend time reading, writing, and talking about values—(grades 7-12) (Price: $149.50) • Scope Activity Kit—"Who Am I" —written at 4th-6th grade level for 8th-12th graders, permits student to explore—how he will behave as a parent, what he is like now, what are the important events in his life, ditto masters are included for related games and exercises for reinforcement of basic skills—(Price: $29.95) • Contact—High-Impact Theme Units —each unit contains: 1) 31 Paperback Texts Anthologies, 2) 31 student logbooks, 3) Giant Posters, 4) Teaching Guide, each unit offers high interest material which is relevant to developing the students' understanding of the content area—(grades 7-12 with reading levels of 4-8)—(Price: $99.50 each) Titles: "Loyalties", "Maturity", "Values", "Getting Together", "Communication" • Scholastic 3 Kindle—"Getting Along" —a sound filmstrip program of self-awareness and values materials for early-childhood (pre-school)— Other Titles: "It's Mine", "Sticks and Stones", "Will You Be My Friend"—(Price: $69.50 each) • Scholastic Instructional Materials Catalog, K-12, 1976-77. • "Becoming Yourself"—brochures describing this program which promotes self-respect and respect for others—(4th-6th graders) (Price: $149.50)

CONTRIBUTOR	MATERIALS
Science Research Associates, Inc. 259 Erie Street Chicago, Illinois 60611 (301) 647-8430 Contact: Jack Kilchenstein	• "Behavior Improvement Program" —a program for elementary school principals, administrative staff members, and counselors to help their classroom teachers promptly and realistically resolve their students day-to-day behavioral problems—(Price: $264.80) • "Involvement-Focus on Self-Development"—Grades 4-6—(Price: $156.50) • Brochures—on each kit
Special Child Publications 4535 Union Bay Pl. Seattle, WA 95105 Contact: Ms. Betty Donati	• *Learning to Be*, Bauer, Hanna (Price: $4.50) • *Educational Therapy*, 3 volumes (Price: $7.50 each) —Introduces, evaluates, and reports on pre-school and public elementary school programs, curriculum, training for teachers, covers specific training (cybernetics and automation, short-term retention, reading) and brings together writings on improvements and new ideas.— • *Understanding Disturbed Children*, Jenkins and Harms (Price: $8.95) • Brochures —Special Child Publications, 1977 catalogue —Brochure on "From Delinquency to Freedom" —Brochure on each of the publications listed above
Syracuse University Division of Special Education and Rehabilitation Syracuse University Press Box 8 University Station Syracuse, NY 13210	• "Book Talk" from Syracuse University Press
U.S. Office of Education Publications Administrative Services Division 400 Maryland Avenue, S.W. Washington, DC 20202 Contact: Jean D. Narayanan	• Educational Programs that Work, 1976, USOE, 208 pages. —a catalogue of exemplary educational programs developed by local school districts and approved by the Joint Dissemination Review Panel, USOE, prior to 31 July 1976—
University Park Press International Corporation Chamber of Commerce Building Baltimore, MD 21202	• *Developmental Therapy*, 1975, Mary Wood, ed., 294 pages. —a textbook for teachers as therapists for emotionally disturbed young children— • "University Park Press"—Newsletter
VORT Corporation 385 Sherman Avenue P.O. Box 11132 Palo Alto, CA 94306	• Behavioral Characteristics Progression (BCP) —a nonstandardized continuum of behaviors in chart form, contains 2400 observable traits, criterion-referenced tool.
Western Burlington County Regional Council for Special Education Mount Laurel Road Mount Laurel, NJ 08054 Contact: Mrs. Furbee	• *Emotionally and Socially Maladjusted Curriculum*, 1974, Western Burlington County Regional Council for Special Education, 1057 pages. —a sequential curriculum for emotionally handicapped children in preschool through grade 12, classes covering the affective-emotional domain as well as the more common cognitive areas—(Price: Cost of duplication)

CONTRIBUTOR	MATERIALS
Yeshiva University Research and Curriculum Center Dr. Herbert Goldstein, Director 55 Fifth Avenue New York, NY 10006 (212) 255-5600 Contact: Tom Harris (301) 679-8443 Charles E. Merrill Pub. Co.	• "Social Learning Curriculum"—Herbert Goldstein —designed to expose the special student to a balanced variety of physical, social, and mental stimuli—(Price: $375.00)

NOTES



Appendix C

CONFERENCE AGENDA
AND
EVALUATION OF PROCEEDINGS

PROGRAMMING FOR THE EMOTIONALLY HANDICAPPED: ADMINISTRATIVE CONSIDERATIONS

TUESDAY — MAY 17, 1977

6:30-8:00 p.m.	Social—No "Host"—*Cabinet Suite*

WEDNESDAY — MAY 18, 1977

8:30-9:00 a.m.	**Registration/Coffee**—*Federal Ballroom (N)*
9:00-9:30	**Welcome**—Dr. Raymond Cottrell, Director MERRC **Overview**—Ms. Linda Foley, Education Program Specialist MERRC
9:30-10:30	"The Challenge to Administrators: Emotionally Disturbed Children and Social Service Agencies"—Dr. Joyce Spence
10:30-10:45	**Break**
10:45-12:00 p.m.	"The Rutland Center—Developmental Therapy Model: A Practical Model for Emotionally Disturbed Children"—Mr. Tony Beardsley
12:00-1:30	**Lunch**
1:30-2:30	"Involving the Parents of Severely Emotionally Disturbed Children in the Treatment Process"—Dr. Richard Simpson
2:30-3:30	"Development of Comprehensive, Self-contained Intervention Packages for Remediating Classroom Behavior Disorders"—Dr. Hill Walker
3:30-3:45	**Break**
3:45-4:30	"The Administration of An Agency That Recognizes It Can Not Be All Things to All Children and Their Families; An Ecological Approach"—Mr. Don Hartstern
4:30-4:45	**Evaluation**—Dr. Joe Todd, Assistant Director CORRC
4:45-5:00	Slide/Tape Presentation (Optional)—Dr. Richard Simpson

THURSDAY, MAY 19, 1977

8:30-8:45 a.m.	**Coffee**—*Federal Ballroom (N)*
8:45-9:00	**Introduction to Day's Activities**
9:00-10:15	"Division TEACCH: Toward a Statewide Network of Public School Services for the Autistic Child and His Family"—Dr. Lee Marcus
10:15-10:30	**Break**
10:30-11:45	"Controlling Academic and Social Performance Using an Instructional Delivery Approach"—Dr. Ed Gickling
11:45-1:15	**Lunch**
1:15-2:15	"The Severely Disturbed Adolescent: One School's System Approach"—Mr. Byron McDonald/Ms. Ann Evans
2:15-3:15	"Cooperative Programming for Behavior Disordered Students: A Model Program"—Dr. Charles McCormick/Mr. Mark Becker
3:15-3:45	**Evaluation**—Dr. Joe Todd, Assistant Director CORRC **Closing Remarks**

Note: A display area featuring recent publications and selected classroom materials will be situated in the conference room for participant perusal during break periods.

QUALITY INN, WASHINGTON, D.C. **MAY 17, 18, 19, 1977**

APPENDIX CONFERENCE EVALUATION

The conference evaluation was designed to provide information on the achievement of conference objectives and input from the presenters. Evaluation forms were prepared for each of the two days and were distributed and collected at the end of the day. The number of responses for each item varies because of items being overlooked or omitted for evaluation by the rater. Of the 65 participants 44 (68%) returned an evaluation form on the first day and 37 (57%) returned a form at the close of the conference on the second day. Parts I and II of the conference evaluation forms are located at the end of this appendix.

Achievement of Conference Objectives

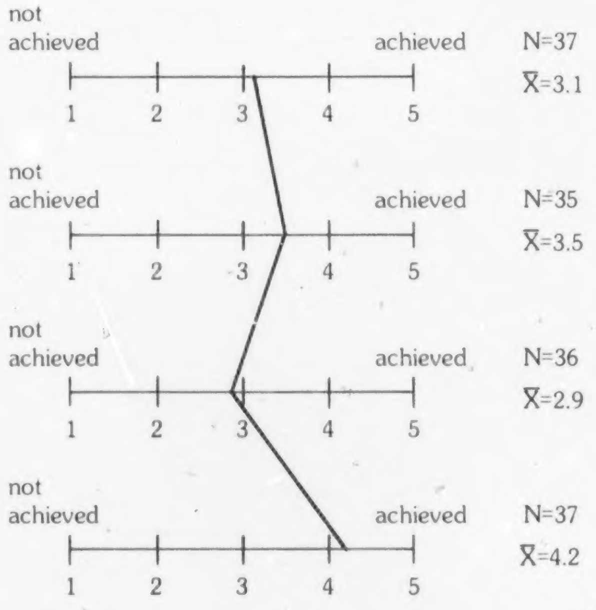
Were the following conference objectives achieved:

A. To aid participants in identifying the emotionally handicapped population

B. To assist participants in implementing service models through discussion of administration level considerations, i.e., program overview, staffing structures, etc.

C. To aid participants in developing an understanding of interagency cooperation for successful service delivery to the EH population within their home state.

D. To develop participants awareness of exemplary service models being implemented by various states at the local district school level.



When participants were asked "How useful do you feel the conference will be to you for developing and/or modifying your present service delivery plan for emotionally handicapped individuals?", 41% checked "very useful" and 59% checked "somewhat useful". No one marked the "not useful" rating. This appears to indicate satisfaction with the utility and practicality of the models presented at the conference.

Comments on good points:

—The description of characteristics for the severely emotionally disturbed was helpful.

—It was interesting to hear the competencies required for working in various intervention models. A knowledge of administrative considerations will be helpful in working with SEAs to plan for new programs for ED children.

—The selection of programs was excellent! It was helpful to hear of programs which worked with preschoolers as well as adolescents.

—Many good models, with some degree of variation chosen.

—Comprehensive.

—Good selection of participants.

—Visual aides were good.

—I'm sure we're all at different points now—definitely not together on identifying (diagnosis) nor the definition, nor who should do it.

—Some good overviews of positive as well as negative concerns from project concerns.

—Glad to see some of the projects I've been hearing about.

—Good description of their individual programs as to points above.

—Excellent

—Excellent identification processes ranging from mildly to severely emotionally handicapped clients.

—Excellent program overviews as well as staffing structures.

—Good cross-section view of exemplary service models—from mildly to severely educationally handicapped.

—Shared some methodology for funding, staffing, etc.

—This conference brought out state's people together outside the bounds of Department sanctions.

—Lots of different ideas for different types of EH children.

—The program varied as to the type of EH child. Programs ranged from ages 0 to 15 and from mild to severe—very helpful.

—Several programs were detailed sufficiently to allow for a decision as to whether or not I wanted to know more.

—The organization of the conference seemed mostly pointed at awareness of programs from a very general viewpoint.

—Gave ideas on difficulty of defining—need for criteria.

—Overviews were great—data on staffing, etc.—Last speaker addressed this well.

—Good variety—various levels (mild to severe)

—Good variety of view points and types of programs.

—Some of the presentations were programs geared toward interagency cooperation and were most worthwhile.

—Good distribution.

—I think I am aware of how to identify a "severely emotionally disturbed", but I was not sure who among these "SED's" should or could remain in the public schools.

—Many interesting models were presented among which we could choose "our favorite".

—I think each of the speakers truly believed in their service models.

—Last presentation was especially pointed to this area. Excellent.

—Interesting to interact with staff and learn of programs in other areas.

—Large range of clients served was presented.

—Coming in contact with these people is definitely a good start in the process of developing communication.

—Recognition of wide variance of ED in terms of severity and behaviors.

—Recognition of problems and limitations.

—Good variety.

—Speakers usually were able to identify the population of children their programs serviced very well. The written material handout by presentors was quite helpful.

—Delineated psychometric and behavioral characteristics.

—Awareness increased of knowledge of other programs.

—Objective D was the strength of the conference for me! Perhaps because as a program development person it is of the highest interest level.

—We have programs similar to several of those presented—equally good!! We were intrigued by different adaptations by different states.

Suggestions for improvement:

—Perhaps the presentation of some checklists for identification of various types by severity would have helped. I think that most of the presentors assumed that there is a concensus on what behaviors identify a child as emotionally disturbed.

—This point was glossed over. The imperity of interagency cooperation was not clearly evident.

—We need more insight into developing cooperative services.

—More emphasis on specific agencies would be helpful, i.e., mental health/social services.

—I'm not sure anyone has obtained "interagency cooperation for successful service".

—All presentors should indicate the state definition *and* the definition they accept (work with) in their own program. (May be different than definition.)

—Federal projects are not up to date on newer regulations that may change their program structure (that state programs must maintain). The (we) state administrators need to know administrative concerns from the State Special Education Director of the state where the project is—not just from administrators of the federal project.

—Presentors did not have exemplary models for the full range of E.H. students—rather they only have it for the autistic or socially maladjusted etc. A project based in a state public school system needs to show how they integrate services. All the presentors were mainly federally funded, not state supported except for Rutland. Where is vocational-education, occupational education, sheltered workshops and state agencies such as Rehabilitation Mental Health, Blind Commission, etc.? Juvenile Corrections County Commissioner Court?

—I hope the papers will pinpoint what the speakers see as aids in identification.

—More emphasis should be placed on fiscal responsibilities—differentiation between fiscal responsibilities of mental health and education.

—Need to have realistic, functional and cooperative programs exemplified in order to provide ideas for interagency cooperation.

—There was no real emphasis on identification. Each program identifies for their own needs. Allowance for all participants to share experiences.

—Have conference participants actually participate.

—More interaction of varied state representatives. In other words, more discussion for interaction rather than questions.

—More different types of programs might be offered.

—Some not LEA programs, but O.K. as models.

—Develop a list of how each state identifies the EH child because it does vary.

—Speakers need to stick closer to purpose of program.

—It was nice to hear a few were having an interagency cooperation because it seems that most programs are not getting this.

—Something for the 15-21.

—Specific descriptive criteria of the EH population from each program with psychometric data—also the criteria for eligibility from each state for what the EH kid is. Incidence rates could have been postulated, etc.

—Variability of populations (i.e., characteristics) was so poorly defined that the programs were difficult to evaluate or compare. More importantly, the descriptions did not really relate to administrative concerns. Few presentors appeared prepared to deal with that type of question.

—I never heard anything about strategies or specific examples of cooperation among agencies. With the exception of urging for liaison personnel nothing was said.

—Subsequent written material on other programs would be helpful. Canvassing other funding agencies such as NIMH could have identified programs which would be helpful.

—Strategies for initial collaborative/cooperative "mind sets"—

—Everything was skimmed over giving little opportunity to explore initial implementation of the programs let alone the evaluation of the present day status of the program.

—Active participation of the conference members—example—give an interagency problem and work it through.

—Most presentations started with identified kids—didn't clearly specify how identified. Where % were given—most did not define criteria or criteria differs.

—Administrative (process) constraints making programs work—what to look at (except last speaker).

—Little help of "How".

—More small group discussion—exchange might have helped make some data more real.

—It did not appear this was addressed, other than in passing. Information given was not new or different.

—Discussion groups/session. More interaction with presenters.

—There continues to be discrepancy between using the emotionally disturbed; emotionally handicapped; emotionally problemed; behavioral disordered; and behaviorally problemed. I would suggest that we as administrators come up with a nation-wide "label".

—Adding a mental health orientation, and other non-educational program advocates.

—Programs selected may gear toward various geographic needs: urban, southern, rural, etc.

—Some better direction in determining what "severely emotionally disturbed" children can remain in the schools and those "SEDs" need treatment outside the school.

—However, we need to begin looking at models which have more basis than "theoretical" notions and concepts. I, though, am unable to do this, and so maybe, no one has this information. Thus, I remain eclectic.

—Only when political ramifications could be ignored could this happen.

—More geared to administrative problem: costs, staffing, etc.

—Inadequate attention in programs.

—Attention to answers to above problems, etc.

—Less emphasis on small model programs and more geared to local school problem with zero reject.

—Review of presenters content.

—More information on what people have done to objectively determine who BD is: i.e., Oregon Research Institute Model. Not interested in a standard "average day"—this was for administrators and I'd like to focus on administrative problems in identification.

—Have people do it. Have people present their talk in advance; i.e.; 30 days and someone (committee) critiques it and sends it back asking for additions, deletions, etc.

—Unless research is emphasized, eliminate most university related programs as they are rarely involved with local LEA.

—Descriptions of populations were the usual qualitative ones generally given and my own experience tells me that "disruptive" in Oregon, etc. is *not* the same as "disruptive" in D.C. We need to do better.

—I think more specific guidelines to the presenters were needed, i.e. ask each to present an organization chart, a staffing list, time line, etc. on overhead projector. They could all have distributed a standard fact sheet on population—age, sex, disability.

—This is difficult to do because so often success comes because of personal commitment of persons involved—particularly in a huge agency.

—Accomplished only indirectly—no opportunity for assimilating this information into a tangible form.

—Too much emphasis on extreme (autistic, etc.)

—Printed information from the participants might have illuminated this aspect as it got lost in most, overall presentations.

—There was great variety in the quality of the models presented and even greater variety in the caliber of the presentations.

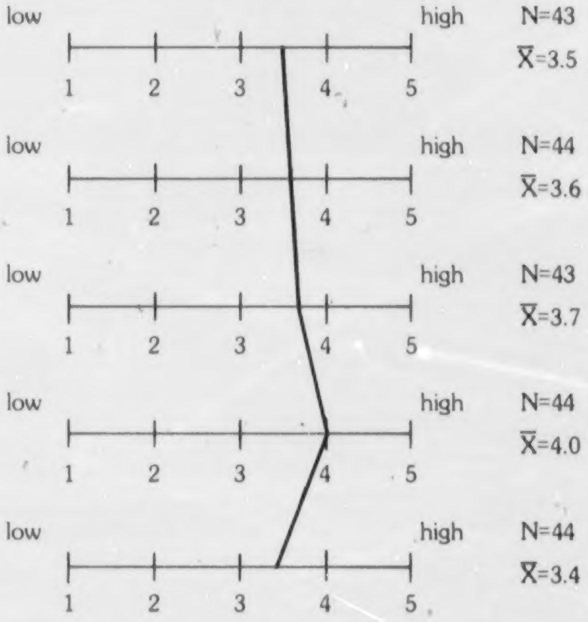
Input from Presenters

Comments on the presentations indicated a positive reaction to the models presented. The participants felt there was a good opportunity for information sharing during each presentation and that much information was shared on an informal interaction of participants during breaks and in the evening.

Participants indicated a need to have a more in-depth explanation of one or two models rather than an awareness of nine programs. Another strong indication was that the presentations did not address clearly enough the objectives established for the conference. Participant comments indicated that too much emphasis was directed toward the programmatic issue of the programs rather than the administrative characteristics necessary to implement the program.

Day 1 Presentations

Please rate the following conference presentations as you feel they added to the attainment of the overall conference objectives:



A. Joyce Spence: The Challenge to Administrators: Emotionally Disturbed Children and Social Service Agencies

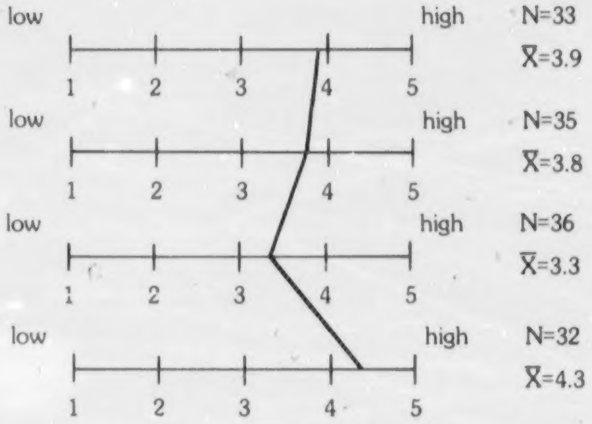
B. Tony Beardsley: The Rutland Center-Development Therapy Model: A Practical Model for Emotionally Disturbed Children

C. Richard Simpson: Involving the Parents of Severely Emotionally Disturbed Children in the Treatment Process

D. Hill Walker: Development of Comprehensive, Self-Contained Intervention Packages for Remediating Classroom Behavior Disorders

E. Don Hartstern: The Administration of an Agency That Recognized It Can Not Be All Things to All Children and Their Families: An Ecological Approach

Day 2 Presentations



A. Lee Marcus: Division TEACCH: Toward a Statewide Network of Public School Services for the Autistic Child and His Family

B. Ed Gickling: Controlling Academic and Social Performance Using an Instructional Delivery Approach

C. Anne Evans and Bryan McDonald: The Severely Disturbed Adolescent: One School's System Approach

D. Charles McCormick and Mark Becker: Cooperative Programming for Behavior Disordered Students: A Model Program

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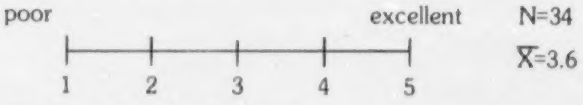
The following was the final question on the evaluation form:

Overall, I consider this conference:



Comments on good points:

—Selection of presenters, selection of workshop site, handout materials.

—Coordinators did an excellent job which we really appreciate.

—Opportunity to meet other people doing similar things and also encountering problems.

—Good overview.

—This was a good start and I hope to see more meetings like this. More meetings in the area of EH to help inform others what's happening in other states. Also talking informally with other state and regional people.

—Helpful in describing generally some projects for E.H. children it was a good awareness conference of some programs for the emotionally handicapped.

—1. We were pretty close to schedule.
2. Organization good—A.V. equipment was ready to go.
3. Materials display.

—I am glad to have the opportunity to receive a document prepared so that I can "reread" the information.

—Enjoyed the conference. The sharing was valuable. Made me appreciate what my school district has.

—Variety excellent.

—Good discussion on important points.

—Meeting Joe and Linda—good resource people. Little interaction with others.

—Size of audience and number of speakers for time span was just right. Location was fine barring the noise from the Post Office group which was unavoidable.

—Opportunity (limited) to identify professionals in other states who might prove to be resources for future conferences, inservice, etc.

—Coffee and sticky buns were excellent. Most grateful for the computer search in the area of E.D.

Suggestions for improvement:

—Let's "organize" a written request to *all* state agencies and ask what the definition of E.D., E.H., B.O., etc. is; who diagnosis; how; and who pays for the services. Then call regional meetings to discuss (seminar) findings and concerns; and review programs for the mild; moderate, and severe E.D. student. University program personnel should be invited as well as one person from SEA, one from Mental Health Agency. Find out which programs were rated the highest and *then* have a states (nation-wide) conference with presenters from each region with highest rate at the conference.

—Philosophy of each speaker did not differ all that much. Nearly all in the field of behaviorism—are there other approaches?

—This program was a showcase (which has purpose); however, I was expecting a higher level. Most of the information should be known by most people attending this meeting. The showcase approach is excellent for people young in the field rather than those who have been around for several years and therefore been exposed to the same or similar programs. Suggestion would be limiting number of participants to a group which could function almost as a workshop with several "experts". The sharing of experiences can be much more educational than lectures.

—Need more administrator-type presentations rather than program models per se. It appears these instructions were given, but perhaps people are more comfortable doing program overviews, etc. Or perhaps administrative and process considerations are not things they explicitly think about. Perhaps a different conference structure would have facilitated this goal. Sessions on specific topics or objectives rather than programs in general.

—More conferences and even better training that some of these programs furnish for their staff. Further workshops and conferences should be set up to meet the needs of specific areas of EH child such as autistic, socially maladjusted, 0-6, 0-15, 4-21, 0-21, etc.

—1. Set up a central definition.
2. Make effort to assess needs of participants.
3. If administrative concerns were the focus—something more should have been done to assure that this would be implemented by the presenters.

—1. More active participation of the audience.
   a. group problem solving
   b. discuss how the program could be utilized in local districts.
2. Mail reviews of the sessions to participants prior to the conference. This would allow participants more ready to digest the information and ask questions.
3. Also survey the immediate expectations of the workshop participants.
4. Research shows that simply an exchange of information does little to change behavior rather the individual needs to be engaged "doing" to some degree, the new behavior. I would strongly recommend the participants in "doing"—and follow-up questionnaire after the conference.

—More information on which kinds of children should remain in schools and which should be in programs outside the public schools (and meet the requirements of 94-142).

—It would have been interesting and rewarding for communication if there would have been some time spent in non-lecture/workshop activities. For example, if part of each day was spent in talking in small groups between and within states as to what programs they have, their problems, and future ideas.

—More information regarding intake/exit, finance, general legal implications.

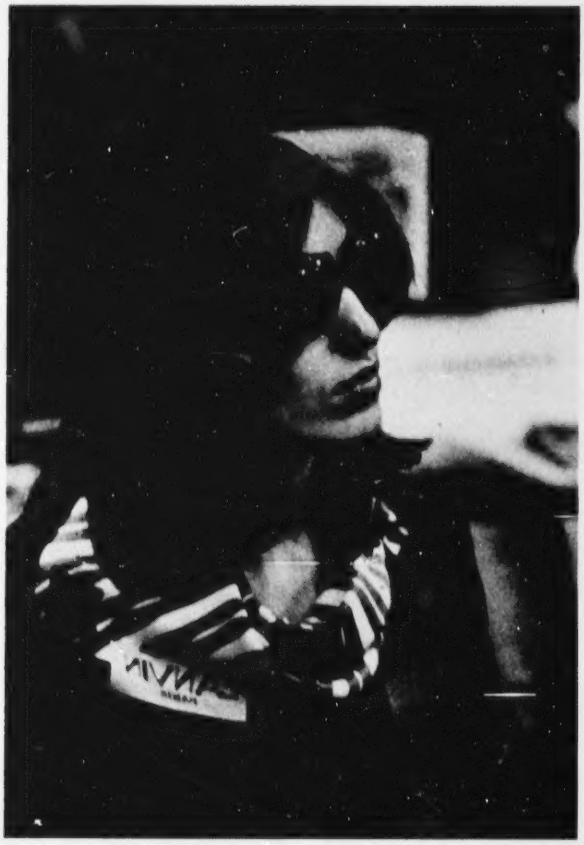
—More time. Maybe some type of seminar approach or time for more questions and discussion.

—More use of faster moving video. Limit details and indicate more administrative issues in running these programs. Poster sessions would be helpful around 4-6 issues held once or twice for an hour, i.e., issues 5-6 Wed.; and 1-2 p.m. Thurs. around: problems of running programs, identification of ED, staff reinforcement, inservice training, what reinforces the administrators. how generalizable is the program presented? Why or why not? How effective is consultation regarding ED kids? What research says about just working with kids rather than with families as well.

—I think one of the days you should have planned a group lunch or dinner with one of the speakers at each table. We have found this very popular at our conferences and it saves a lot of time at lunch because of persons not having a problem getting back late! I have already commented on standard information and pre-conference materials.

—More variety in format—especially in the presentation of information.

—1. Careful consideration of format for conference.
2. Quality of presentations!
3. More opportunity to talk to consultants and colleagues from other states.



Appendix D

CONFERENCE PARTICIPANTS

I. Production Staff
II. Presenters
III. Attendees

Conference Production Staff

Manfred Brand—MERRC
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Linda Foley—MERRC
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Amy Green—MERRC
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Carol A. Holland—MERRC
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Joseph C. Todd, Ed.D.—CORRC
University of Kentucky
114 Bradley Hall
Lexington, KY 40506

Conference Presenters

Anthony Beardsley—Director
National Technical Assistance Office
Rutland Center
698 North Pope Street
Athens, GA 30601

Ed Gickling, Ph.D.
1509 Westop Trail
Knoxville, TN 37919

Don Hartstern—Executive Director
YMCA Youth Residential Center
Chattanooga, TN 37408

Lee Marcus, Ph.D.
Piedmont TEACCH Center
Department of Psychiatry, 5-South
School of Medicine
University of North Carolina 27514

Charles McCormick, Ed.D./
Mark L. Becker—ASCW
145 Fisk Avenue
De Kalb, IL 60115

Byron McDonald/Ann Evans
Bailey School
81 Florence Street
Pontiac, MI 48058

Joyce Spence, Ph.D.
The Child Center
3995 Marcola Road
Springfield, OR 97477

Richard Simpson, Ed.D.
Special Education Department
CRC 103
Rainbow Blvd. at 39th
Kansas City, KS 66103

Hill Walker, Ph.D.
CORBEH
1590 Willamette Street
Eugene, OR 97401

Mary McCaffery, Ed.D.
The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(document contributor)

Conference Attendees

Peter Albrecht
Commonwealth of Kentucky
275 E. Main Street
Frankfurt, KY

Lis Altschul
State Dept. of Education
P.O. Box 8717—BWI
Baltimore, MD

Lucile Anderson
State Dept. of Education
Richmond, VA 23216

Mary Jo Banta
Bureau of Education for Ex. Ch.
Capitol Towers
Frankfort, KY

Sandra Barkey
State Dept. of Education
c/o Kanawha City Schools
200 Elizabeth Street
Charleston, WV 25311

Duncan Baugh
State Dept. of Education
Room 404—Cordell Hull Bldg.
Nashville, TN 37219

Dea Boker
Illinois RRC
3202 N. Wisconsin
Peoria, IL 61603

Irene Bolton
State Dept. of Education
Richmond, VA 23216

Judy Buffmire
Utah SEA
250 E. 5th Street
Salt Lake City, UT 84111

Manfred Brand—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Mary Lou Brewster
State Dept. of Education
c/o Wood City Schools
Parkersburg, WV 26101

Faye Brown
SERRC
Auburn University
Montgomery, AL 36109

Ray Bryant
Board of Education
P.O. Box 619
Cambridge, MD 21613

Janis Carroll
Dept. of Public Instruction
Education Building
Raleigh, NC

Carolyn Cobb
S.D.P.I., Div. PPS
Education Building
Raleigh, NC 27611

Raymond S. Cottrell—Director—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Alan Coulter—TRRC
211 E. 7th Street
Austin, TX 78701

Jackie Crain
Illinois Office of Education
100 N. First Street
Springfield, IL

Emily Crandall—MERRC
Mid-East Regional Resource Center
The George Washington University
Washington, D.C. 20006

Claire D'Agostino
DE Dept. of Public Instruction
Governor Bacon Health Center
Delaware City, DE 19706

Eric Darling
NERRC
168 Bank Street
Hightstown, NJ 08520

Ted Drain—Director
Division for Ex. Ch.
Dept. of Public Instruction
Raleigh, NC

Kathleen Dyer
SERRC
P.O. Box 611
C'sted, St. Croix
Virgin Islands 00820

Joellen Flores
Texas Education Agency
Special Education Division
201 E. 11th Street
Austin, TX 78701

Linda Foley—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Suite 505
Washington, DC 20006

Anita Foxworth
NWLRS
Clinical Service Building—3rd Fl.
University of Oregon
Eugene, OR

Marjorie Gazvoda
George Washington University
2201 G Street, N.W.
Washington, DC 20052

Ann Geraghty
BEH/Aide to States
400 Maryland Avenue, S.W.
Washington, DC

Myrtle Glatzer
MS State Dept. of Education
Room 702
Jackson, MS 39205

B. E. Goocher
Edgefield Lodge
Rt. 2, Box 61
Troutdale, OR 97060

Marlene Guy
Alternative School/D.C. Public Schools
429 O Street, N.W.
Washington, DC

Bill Harrington
Division of M.H.S.
1733 Euclid Road
Durham, NC 27713

Helen Hill
State Dept. of Education
Richmond, VA 23216

Carol A. Holland—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Suite 505
Washington, DC 20006

Len Jozwiak
DE Dept. of Public Instruction
Governor Bacon Health Center
Delaware City, DE 19706

Jan Kerr—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Suite 505
Washington, DC 20006

Sharon Lassetter
LA State Dept. of Education
Division of Special Education
P.O. Box 44064
Baton Rouge, LA 70804

Evelyn May
West Virginia Dept. of Education
Building 6
315 B Capital Complex
Charleston, WV 25305

Ann Margolis
George Washington University
2201 G Street, N.W.
Washington, DC 20052

Larry Martin
Auburn University/Montgomery
Montgomery, AL 36117

Littleton Mitchell
Governor Bacon Health Center
Box 38
Delaware City, DE 19706

Donald Moody
Bundy Alternative School
429 O Street, N.W.
Washington, DC

Jim McLeod
NWRRC
Clinical Service Building
University of Oregon
Eugene, OR

Ed Necco
Marshall University
Huntington, WV

Diane Petersen—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W
Washington, DC 20006

Judy Reiner Platt—MERRC
Mid-East Regional Resource Center
The George Washington University
1901 Pennsylvania Avenue, N.W.
Washington, DC 20006

Shirley Sanford
Special Education Division
Texas Education Agency
201 E. 11th Street
Austin, TX 78701

James Sebben—DMH—MR
P.O. Box 1797
Richmond, VA 23214

Ann Terrell
Dept. of Education/Division of ED
1042 Whetstone Way
Louisville, KY 40223

Peggy Thorpe—NERRC
168 Bank Street
Hightstown, NJ 08520

Joseph C. Todd—CORRC
Coordinating Office for Regional
Resource Centers
University of Kentucky
114 Bradley Hall
Lexington, KY 40506

Susan Turner
Bureau for Health Services
275 Main Street
Frankfort, KY 40601

Christa Vanderbuilt
Terry Center
RD 2 Fawnhome
Kennett Square, PA 19348

Carol Vinograd
Terry Center
10 Central Avenue
Newcastle, DE

Lila Webster—SERRC
435 Bell Street
Room 105
Montgomery, AL 36104

Tom Wilds
4820 Howard Street, N.W.
Washington, DC

Enid Wolf
415 12th Street, N.W.
Washington, DC

James Wright—SERRC
Auburn University
Montgomery, AL

Pat Wright
14501 Avery Road
Mark Twain School
Rockville, MD 20853